Public Board of Directors
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Private/ public paper:	Public paper
Report Title:	**Patient Safety and Learning Report for Quarter 1**
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Vision and values:	This supports the Trust's vision regarding **continuous improvement of services** and **ensuring excellent services**. This report addresses **working together** and that we keep improving, in understanding patient safety issues and learning from these.
Purpose:	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:	**Assure** The report provides assurance that the Trust continues to embed the patient safety incident response framework (PSIRF) and is maturing its learning and improvement culture. Learning is triangulated across multiple sources—including patient safety incidents, safeguarding concerns, complaints, freedom to speak up, and external reviews—ensuring a system-wide approach to safety. Oversight is maintained through the patient safety overview panel, clinical quality and safety group, and the newly established learning and improvement group. High levels of incident reporting have been sustained, with most incidents resulting in low or no harm. Improvement work is aligned to the five patient safety priorities: unexpected deaths, self-harm, medication errors, restrictive practice, and falls, with measurable progress in each area. **Alert** The report highlights several recurring and cross-cutting risks: • Risk assessment remains inconsistent and insufficiently personalised across services. • Substance misuse and dual diagnosis continue to challenge staff confidence and joint care planning. • Discharge and transfer safety issues persist, particularly in coordination with acute trusts. • Domestic abuse enquiry processes require broadening to include adult family violence and high-risk groups. • Digital integration gaps hinder timely information sharing and care coordination. • Staff confidence and culture impact the management of restrictive practices, safeguarding, and inclusive care. These risks are evident across multiple data sources and require sustained attention.

	Advise The Board of Directors is advised to note and support the following key actions: • Full rollout of the personalised assessment of risk (PAR) tool across services occurring October 2025. • Implementation of the dual diagnosis policy and joint working with substance misuse services which is already underway. • Piloting and evaluation of new discharge protocols with Sheffield Teaching Hospitals which is underway, review occurring in September 2025. • Development of a working with perpetrators toolkit and enhanced domestic abuse enquiry processes. • Expansion of respect training to include trauma-informed care and neurodiversity occurring September 2025. • Continued investment in digital integration and system-level improvements which is ongoing. These actions are monitored through the centralised learning into action plan and governance groups, ensuring accountability and impact.

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.	
Statutory obligations under the **patient safety incident response framework (PSIRF)**, a national requirement from NHS England for all NHS Trusts. 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	
BAF and corporate risk/s:	**BAF 0024** There is a risk that the organisation fails to meet fundamental standards of care, legal, regulatory, and safety requirements. **BAF 0031** There is a risk that the Trust fails to maximise its contribution to reducing inequalities **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 1 was presented to the Quality Assurance Committee in September 2025.

Recommendation:	The Board of Directors is asked to: • **Receive assurance** that the Trust maintains a strong incident reporting culture, evidenced by consistently high levels of reporting, particularly of near-miss, negligible, and low-harm incidents reflecting openness and a proactive approach to safety. • **Endorse the continued strategic focus** on the five patient safety priorities: unexpected deaths, self-harm, medication errors, restrictive practice, and falls, and support the improvement initiatives underway to address these areas through targeted quality improvement and governance oversight. • **Receive assurance** that the Trust is effectively triangulating learning across multiple sources including incidents, safeguarding, complaints, Freedom to Speak Up, and external reviews to identify key safety themes and drive coordinated, system-wide improvement.

Public Board of Directors

Patient Safety and Learning Report Quarter 1 2025/26

Purpose:

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.

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.

Learning and Safety Report

Patient Safety Incident Response Framework Learning Responses

This section provides an overview of the learning responses undertaken by the Trust during Quarter 1 (Q1) of 2025/26, 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.

Table 1: Learning Responses actioned in Q1

Type of Response	April 25	May 25	June 25	2025/26 Q1	2024/25 Q4
PSIRF 48hr Reports Requested	12	11	7	30	16
48hr Reports - Patient Death Reportable to HM Coroner	6	5	4	15	15
Local Learning Reviews (LLR) Declared	2	1	20	5	6
Coordinated Learning Review (CLR) Declared	0	0	1	1	1
After Action Review (AAR) Declared	2	4	1	7	2
Duty of Candour	8	1	2	11	N/A
Structured Judgement Reviews (SJR) Declared	0	0	0	0	2
Patient Safety Incident Investigations (PSII) Declared	0	1	0	1	1
Manager Incidents Reviews Actioned.	642	599	591	1832	1824
Daily Incidents Safety Huddle (DISH) Actions	289	261	254	804	600
Blue Light Alerts	0	1	1	2	2

Key Insights and Developments

- **Patient Safety Incident Investigations (PSII):** One PSII was declared in Q1, This investigation relates to problems with Rio demographics (namely addresses) not transferring from Insight in the right way, leading to Trust-wide problems with out-of-date addresses and several data breaches, due to letters containing sensitive (clinical) information being sent to the wrong addresses in 27 of cases. This was also reported to the Information Commissioners Office.

- **Local Learning Reviews (LLRs):** Five LLRs were declared in Q1 and seven After Action Reviews (AARs) were declared, which is a significant rise and reflects an ongoing focus on 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. Training is due to begin in October. Themes of learning responses include responses to physical health deterioration, physical assaults, unexpected deaths, self harm and restraining.

- **Changing Practice – Immediate Learning Huddles:** A pilot of immediate learning huddles is underway in two service areas (Burbage Ward and the Decisions Unit/Health Based Place of Safety). 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. The pilot will take place over one quarter and evaluated with the teams in October.

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.

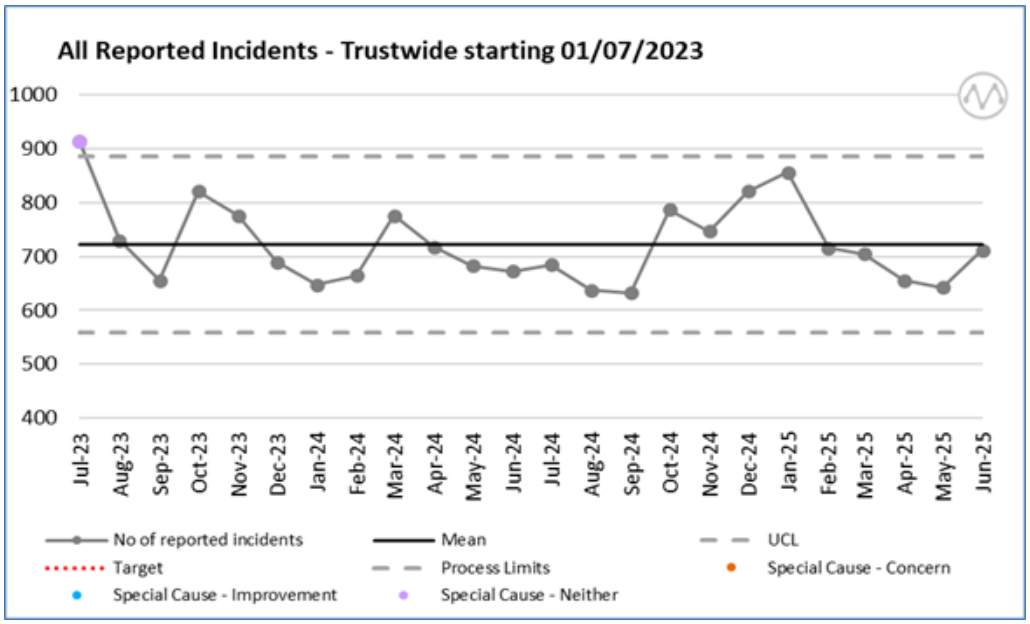
The DISH reviewed 100% of reported incidents within 24 working hours during Q1.
Of the 2012 incidents reviewed, 40% were followed up directly by the DISH team to provide support or request further information. This is a significant increase of 15% from last quarter and reflects a proactive approach to ensuring timely learning and appropriate escalation.

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 two years.

While figure 2 shows a reduction in incidents reported in Quarter 1 compared to previous quarters, this is within normal variation.

Figure 1: Patient Safety Incidents reported July 2023 – June 2025



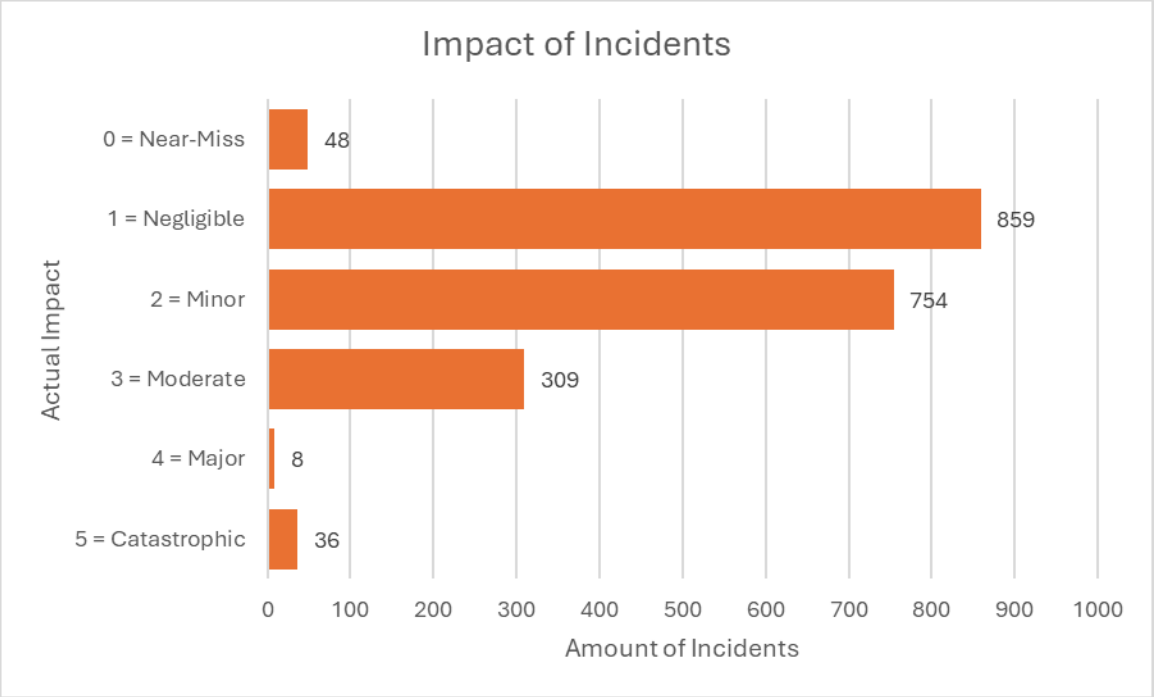
Key Incident Insights – Q1 2025/26

There has been no significant variation in incidents reported across SHSC's directorates.

83% of all reported incidents in Quarter 1 were categorised as no harm or low harm, which is within usual variation.

Figure 2 below shows the breakdown of the actual impact of incidents reported during quarter 1.

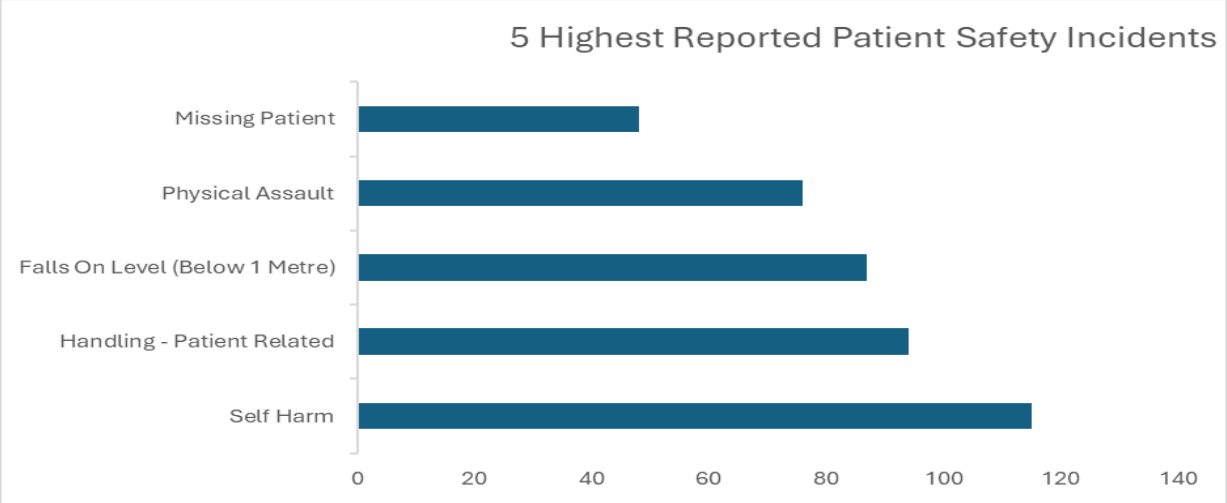
Figure 2: Actual impact of incidents reported in Q1 (2025/26):



Highest Patient Safety Incidents Reported

Figure 3 below shows the breakdown of the top 5 highest categories of patient safety incidents reported during quarter 1.

Figure 3: Highest Categories of Patient Safety Incidents Reported in Quarter 1 2025/26



The highest reported patient safety incidents align with the patient safety priorities identified by SHSC.

To note, there has been an increase in missing patient incidents. This has been analysed and relates to an increase in Forest Close incidents relating to one patient. A local learning review was requested to explore the missing person incidents for this patient and assess if there are any systemic issues that can be acted upon and will be reported on in quarter 2. In addition, the missing person incidents were all handled inline with the Trust's Missing Person Policy, and the patient was noted to have returned safely in all incidents.

Overall, this increase in missing patient incidents does not suggest an overall increase across the Trust.

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.

Table 2: Patient Safety Incident Response Plan Priorities

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

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.

Relevant datasets for the above five priorities, as well as other priorities such as violence and aggression, can be found in Appendix 1 and are referenced throughout this report.

Priority 1 - Unexpected Deaths

What does our data show?

In Quarter 1, the number of reported deaths remained consistent compared with Quarter 4 of 2024/25.

SHSC treats all deaths with the utmost seriousness. Each natural cause death 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. Details of this process and data not captured within this report and is reported in the quarterly Mortality Report.

Key insights:

- Of all death-related incidents, 71% were classified as unexpected, including both natural and non-natural causes, which is higher than the previous quarter's figure of 60%. This is due to an increase in deaths from natural causes.
- Unexpected deaths not from suspected natural causes decreased by 6%, and suspected suicides accounted for 9.5% of all death incidents. This is within usual variation and slightly higher than last quarter due to the overall number of unexpected non-natural causes deaths reducing.
- Ethnicity of patients who have died has not significantly changed in the last 2 years, and white men are the highest reported demographic of patients who die – however a large proportion of people who die do not have a recorded ethnicity. This shows that is important for us to improve on data quality, particularly in an area as significant as the end of a patient's life.

Overall, the Trust is on a slight downward trajectory for suspected suicide death. There was a slight increase in April which accounts for the overall percentage being higher than the previous quarter. All incidents resulted in a 48-hour report as a minimum. These have been reviewed and there is no cross over of themes or suggestion of missed opportunities within SHSC services that would account for a rise, and this appears supported by the reduction in suspected suicides over May and June.

Is the data impacted by any known improvement initiatives?

As any death by suicide is one too many, there remains a critical need to better understand and prevent suspected suicides among individuals receiving care through SHSC.
Although Quarter 1 revealed limited crossover themes in learning from these incidents compared to previous quarters, continued improvement in this area is essential. Strengthening both proactive and reactive approaches to assessment and care will support more effective interventions and ultimately contribute to safer outcomes for service users.

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. 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. It has proven to be successful amongst the SHSC pilot teams, closing known gaps in practice and supporting more comprehensive risk formulations which then lead to effective risk management plans. As the pilot has been successful, the PAR will be rolled out to all services in October.

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. However, this has not proven to improve care planning and, as such a back-to-basics programme is being developed to provide training for staff in this area. This will be implemented from October. An audit of care plans is taking place to direct and drive further improvement.

Thematic Review of Unexpected Deaths:
As reported on in the previous quarter, a comprehensive thematic review of unexpected deaths is currently underway. The review has been drafted and will be presented to the Clinical Quality and Safety Group in September. Engagement with service users and families will take place in October, this has been slightly delayed by capacity and resources.

Centralised Learning into Action Plan:
This has been separately reported on to the Quality Assurance Committee, and in the previous quarterly patient safety report. The next steps of this plan are to refine recommendations around the Home First programme and establish continuous monitoring meetings, this is expected from the end of September.

Learning Identified This Quarter

There has been a wealth of learning identified this quarter through learning responses following unexpected deaths. It is imperative that we take learning from unexpected deaths and act on this to create improvement in services.

The below table addresses learning taken from learning responses around unexpected deaths – please note that the learning has not identified factors contributing to patient's deaths but is noted as areas we need to strengthen.

Table 3: Learning themes/improvement areas from unexpected deaths

Theme of learning	Breakdown	Improvement Actions	Improvement outcomes	Where monitored
Positive assurance - Assessments at points of crisis	Several 48-hour reports for patients who presented at Liaison Psychiatry identified thorough needs based assessments had taken place.	To share this learning in team forums	Comprehensive needs-based assessments were noted to have supported service users to be open about their difficulties and	Not applicable

Theme of learning	Breakdown	Improvement Actions	Improvement outcomes	Where monitored
			engage in their own risk management and safety planning.	
Liaison with other services	One report advised of concerns with an **inappropriate discharge** from Sheffield Teaching Hospitals to SHSC wards	A **new process** is being piloted at STH with guidance regarding discharges to SHSC. Physical health team will input into this. In addition, STH are undertaking an internal review via a Structured Judgement Review and will feed back findings to SHSC.	The process supports SHSC staff to understand information they should receive and what they need to seek if not available. It supports STH staff to understand appropriate discharges to SHSC.	Clinical Quality and Safety Group
Systems & Data Integration	A theme of disjointed digital platforms hindering **timely information sharing** (such as staff not having access to SystemOne). While not contributing directly to deaths, integrated information sharing would support joint working.	There has already been development to integrate Rio and Iaptus. The digital team are exploring how to integrate System1 and Rio.	There are significantly more difficulties integrating System1 and Rio, and we may not see the output of this action for some time.	Centralised Learning into Action plan
Co-morbid substance misuse and mental health concerns	A theme of SHSC staff feeling unconfident working with patients who also have a co-occurring substance use concern, and difficulties joint care planning with substance misuse services. This has been noted in two learning responses.	Review and develop a dual diagnosis policy. Joint working groups between SHSC and Likewise (the substance misuse service) have been implemented.	The Dual Diagnosis policy has been drafted and will be shared with oversight groups in August. The groups with Likewise are receiving positive feedback and beginning to resolve joint working concerns. From this, **training needs** regarding dual diagnosis	Clinical Quality and Safety Group & Centralised Learning into Action plan.

Theme of learning	Breakdown	Improvement Actions	Improvement outcomes	Where monitored
			have been identified and are being acted on.	

Priority 2 – Self-harm

What does our data show?

In Quarter 1, **self-harm incidents reduced by 4% from the previous quarter.** This is the second quarter that a reduction has been seen and continues to represent a positive shift in the care of self-harm. It should be noted these figures are reflecting small reductions in incidents and could be normal variations – and as such more monitoring will be needed in subsequent quarters to identify if this reduction amounts to special causes. Last quarter, it was reported that **psychological recruitment** was taking place. This is now in place on acute wards and appears to be contributing to a reduction in self-harm behaviours.

Key observations include:

- Burbage Ward saw a significant reduction in self-harm incidents, from 151 in the previous quarter to 59 in Q1, contributing positively to the Trust-wide trend. This relates to above reported psychological recruitment, as well as previously reported improvements in consistent post incident reviews with patients following self-harm incidents.
- In the previous report, hHBPoS incidents had risen by 14 from 0. This has continued into Q1 with 12 incidents overall. A themed After-Action Review has taken place with the team regarding self-harm and improvement work, such as reviewing the MDT needs of the team, is ongoing and will be reported on in Quarter 2.
- **Ethnicity** of patients who self-harm remains within normal variation; the majority of self-harming patients are white female inpatients. There has been an improvement in the recorded ethnicity of those who self-harm.
- The majority of incidents were recorded as **no harm** or **low harm**, consistent with previous trends.
- Eight incidents were classified as **moderate harm**. These have been reviewed, several of the incidents resulting in learning responses which are addressed below. In all incidents, the moderate rating was applied as the patient attended Sheffield Teaching Hospitals. Patients were responded to in a timely manner, and help sought immediately.

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 considering some increased lengths of stay within the HBPoS. This is on the **risk register** and there is improvement action underway.

Next Steps and Future Focus for self-harm

<u>Trauma informed care</u>

- Psychologists have been recruited to support implementation of trauma informed care across inpatient settings.

- Engagement events with staff and service users have taken place regarding the self-harm thematic review to understand if the thematic review results accurately reflect current care. With involvement of staff and service users at these events, actions have been developed. The main action is:
    - A caring for self-harm guide for practice which will be coproduced with experts by experience and staff). This will provide a structured programme to upskill staff, including introducing a toolkit to support in real time and training. This project is in the scoping phase and more information including expected timescales will be provided in the next quarter. This will support with consistent, compassionate and effective care.
- An evidence-based women's model of care is being developed to ensure that staff delivering care in female wards deliver care specific to the needs of women accessing care. This will be launched in February when the new ward opens.

Learning Identified This Quarter for Self-Harm – Key Themes/Trends

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

Table 4: learning from self-harm

Theme of learning	Breakdown	Improvement Actions	Improvement outcomes	Where monitored
Individualised assessments	• Reviews of risk assessments identified they were not always personalised or contained formulations that guided risk management and mitigation • Assessors with previous knowledge of patients enabled more nuanced assessments. • Risk assessments for patients did not always acknowledge or address how to manage environmental risk	The personalised assessment of risk project is rolling out with an expected date of October. This addresses the learning identified in Quarter 1.	The PAR project has been well received and notably improved risk assessment and management where it has been trialled.	Clinical Quality and Safety Group Centralised Learning into Action Plan
Communication & Coordination	In a joint learning response with STH, there was an identified lack of awareness regarding responsibilities of Liaison Psychiatry and the AMHP team	Create and share role guides for all mental health-related teams. This is planned to be in place October 2025.	As yet, there are no improvement outcomes. PSOP in addition identified that they were not assured the actions were robust enough, and joint	Patient Safety Oversight Panel

	in comparison to the Emergency Department team. This led to decisions taken by STH not being communicated to the AMHP team or made in partnership.	Explore interoperable systems to improve clinical visibility across teams. This is an action STH are leading on and are currently scoping.	work is being undertaken with STH to strengthen actions.	

Priority 3 - Medication Errors

What does our data show?

Medication incidents accounted for **14% of all reported incidents** across SHSC in Quarter 1 which is within usual variation. Of these:

- **18%** were related to **medication administration**,
- **7%** were linked to **prescribing issues which is a slight increase of 2%**, and
- The **majority** fell under **medication management concerns**.

This is similar to the previous quarter.

Medication management incidents encompass a range of issues, including missing second signatures, incomplete temperature monitoring, and discrepancies in controlled drug records. These are not patient safety incidents however could contribute to further patient safety incidents. These findings highlight the ongoing need for robust systems and oversight in medication handling processes.

There were **six moderate medication-related incidents** reported in Quarter 1, representing similar figures to the previous quarter. The majority of these incidents relate to medication not administered by SHSC. Each incident has been reviewed, with learning and actions identified as follows:

Table 5: themes from moderate medication incidents

Incident	Theme	Improvement Actions	Any areas for escalation
Door **lock malfunction** delaying medication access. The lock took some time to be fixed.	Environmental Vulnerability & Escalation	Reviewed escalation processes; managers to contact Estates when needed for faster resolution	This has been acted on and monitored through the Medicines Optimisation Committee
Patient at Forest Lodge missed **prescribed insulin**	Medication Safety & Staff Training	Delivered training to nursing staff on diabetes and medication handling; no harm to patient	This was acted on through Forest Lodge Enhanced Support Plan
Patient at Northern General Hospital (NGH) administered an **overdose** of olanzapine	Communication & Information Handover	Improved handover protocols from Liaison to NGH; emphasized verbal + documentary transfer; promoted use of Summary Care	

Incident	Theme	Improvement Actions	Any areas for escalation
		Records	
Broader issues with **Summary Care Records** accessibility via GPs – mental health trusts cannot access/ensure they are amended.	External Factors & Collaborative Learning	Raised concern across healthcare groups, aiming for shared learning and system-wide improvements	This is being escalated in Area Prescribing Groups in September, as this is not just a local issue.

Medication Safety – Impact of Improvement Initiatives and Learning from Q1
Impact of Improvement Initiatives

Several longer-term improvement efforts are underway. The previous Patient Safety report advised of these initiatives, including

- **Staff Confidence in Medication Administration**
- **System-Level Exploration**
- **Operational Process Review**

Since the previous report, it has been identified that improvement from the above initiatives is slow and there is a need to further expand the nursing action plan and understand what systems concerns the plan is not addressing. This is taking place throughout September and will be further reported on in quarter 2.

Learning Identified This Quarter

Table 6: learning from medication incidents

Theme of learning	Breakdown	Improvement Actions	Improvement outcomes	Where monitored
Safety & Security Concerns	Inadequate individual key management is creating safety risks in Acute wards. There have been several incidents of keys going missing including medication keys. This compromises physical security for patients, particularly where medication keys have gone missing, and has cost SHSC several thousands of pounds replacing locks.	New key management system to be introduced, the funding has been agreed for this. This will reduce physical keys and the possibility of them being lost. Physical keys which are needed are now kept on securely attached belts.	Belts have been introduced on wards and are supporting to keep keys secure.	**Executive Management Team.**
Transfer Processes	A lack of communication from STH about	As reported above, a new transfer process	The trial with STH is being reviewed for efficacy.	**Medicines Optimisation Committee.**

Theme of learning	Breakdown	Improvement Actions	Improvement outcomes	Where monitored
between Acute Trusts and SHSC	medication needs for patients being transferred to SHSC, including that oxygen prescribing was needed. Staff did not understand how to prescribe oxygen or source emergency oxygen and did not know to look for available policies.	from STH to SHSC is being trialled. This is being reviewed for effectiveness and further roll out in September. The report was shared with medical education to explore whether staff are using Jarvis to find policies. There Oxygen policy is being revised to reflect the learning.	Older adult wards have been appraised of the new process and checklists to support staff confidence when accepting transfers, and incidents of inappropriate discharges have reduced.	

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. Improvement initiatives are also reported on in the Least Restrictive Practice quarterly reports.

Key insights for restrictive practice

- Over the past 12 months, the use of **physical restraint** has remained **broadly stable**, with minor fluctuations within expected variation.
- The amount of physical restraint incidents in Quarter 1 has remained stable in line with variation from previous quarters.
- Use of **rapid tranquilisation** has continued to **significantly reduce** following the downward trajectory from the previous quarter, and this is positive.
- There were no significant variations regarding **ethnicity.** SACHMA continue to provide proactive in person support to ethnically diverse patients where restrictive practice has been used.
- To note, **seclusion episodes** did rise in Quarter 1 compared to previous quarters. It is important to learn from this while reflecting that this is in the context of an overall sustained reduction in seclusion over the last 2 years. On analysis:
    - These episodes related to a small number of patients where there was significant risk to other patients and staff.
    - In all cases de-escalation and less restrictive approaches such as rapid tranquilisation were utilised first.
    - Seclusion was deemed to be the **least restrictive option** in some cases, to avoid prolonged restraint periods.

- The Respect team is always involved following the use of restrictive practice to support learning and to support individuals and teams involved in incidents.
- The majority of incidents were reported by Endcliffe, and the majority related to one individual who was acutely unwell and, due to neurodiversity, struggled with the ward environment. A decision was taken to utilise **long-term segregation** to avoid concurrent seclusions. In addition, a consultant psychologist from the Learning Disability Service provided inreach to support the patient and the team with the environment and to safely re-integrate. The person has now been successfully re-integrated into the wider ward.
- **Learning from this** is being taken forward by the ward, including acting on needed environmental changes and building learning around supporting neurodiversity into ward practices. Timescales for this are dependent on funding. Learning is also being shared wider, and amendments are being made to Respect level 3 training to include a module on neurodiversity. This will be in place in September.
- **Hope(s)** training is being bolstered and rolled out wider in September.
- There is a support package being considered for Endcliffe partially because of increasing incidents.

Is this data impacted by any known improvement initiatives?

- **Respect training** has been amended to include more scenario-based incident training with a focus on de-escalation, and supportive engagement around issues such as self-harm. The training also supports staff to understand best practice around incident reporting. It is likely this has contributed to the downward trend of rapid tranquilisation.
- **Post incident reviews** with patients are more consistently applied to wards with a historically high amount of rapid tranquilisation incidents such as Burbage and Endcliffe. This is supporting to apply patient focused and trauma informed care to incident management. Burbage has seen a significant reduction in restrictive practice partially linked to this work.

Next Steps and Future Focus

A high-level restrictive practice improvement plan is being developed to address concerns raised by benchmarking incident data with other Trusts. SHSC has, as addressed earlier in this report, developed a low threshold for incident reporting and ensures it follows the Use of Force Act in reporting all incidents of restraint. However, SHSC is, in some months, benchmarking higher than other local Trusts, and this reflects that there is more to be done to build upon the progress we have made in reducing restrictive practice. This has been escalated and there is oversight from executive directors.

In addition, there is work to address:

Figure 12: improvement initiatives in reducing restrictive practice

Action	Detail of implementation	How this will improve care	Where monitored
Ward Culture and Leadership	Blanket restriction champions are being implemented on wards More Respect trainers are being upskilled to	National reviews have highlighted that ward culture improvement actions directly lead to safer and more therapeutic	Least Restrictive Practice Oversight Group

Action	Detail of implementation	How this will improve care	Where monitored
	work directly on wards and contribute to culture. Timescales are dependent on staff availability – which is on the corporate risk register 5220. A new trauma informed care model is being piloted on the newly built ward which will open February 2026.	interventions.	
Staffing and multi-disciplinary support	Recruitment of psychologists has occurred to feed into least restrictive risk formulations. The standard operating procedures of the Respect team are being reviewed to enable greater daily support to wards and includes greater monitoring of what is needed in clinical areas. This will be reported on through LRP summary reports. The race equity officer attends the DISH to monitor and follow up on needs of our diverse community	This will enable a multi-disciplinary approach, involving experts in the field, to reducing restrictive practice and promoting psychologically safe approaches to managing risk	Least Restrictive Practice Oversight Group
Staff training	Changes to Respect training were reported on last quarter and continue to contribute to staff confidence managing incidents without restrictive practice. The training is also being amended to support learning for community teams. Training around	Staff confidence and knowledge is essential to enabling staff to act in the least restrictive manner when facing difficult incidents. Limited confidence may lead to risk adverse and restrictive interventions.	Reducing Restrictive Practice Group Feeds into Least Restrictive Practice Oversight Group

Action	Detail of implementation	How this will improve care	Where monitored
	positive approaches to dementia, to support restrictive practice amongst this community, is also being scoped. Respect level 3 training is also including a module around supporting neurodiversity – by September. A recovery plan for Bank staff training, including Respect training, is being developed and should be in place September		
Use of Force Care plan monitoring	Exploring and monitoring quality and use of force care plans Following this, there will be considerations around auditing	The respect team will work with the wards to improve the quality and use of these plans – this is ongoing Learning from good quality plans will be shared across wards	Reducing Restrictive Practice Group Feeds into Least Restrictive Practice Oversight Group

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.

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. All incidents were rated as low or no harm in Quarter 1, and this reflects **the impact of improvements** reported on last quarter, such as:

Table 7: Improvement initiatives in falls

Action	Detail of implementation	How this will improve care	Where monitored	Any issues for escalation
HUSH Huddles (huddling up for safety)	These huddles happen daily across older adult inpatient and care home settings.	HUSH huddles focus on steps needed to support falls safety for the day and ensure consistent	Falls Prevention Group. Physical Health Management Group.	None

Action	Detail of implementation	How this will improve care	Where monitored	Any issues for escalation
		messages to the team. The Huddles have directly contributed to a significant reduction in falls incidents.		
Falls observation levels in dementia tool	A new structure to observation levels for falls risks has been piloted on G1 Ward	This supports improved understanding and enactment of observations for people who are high risk of falls	Falls Prevention Group. Physical Health Management Group.	None
Interim falls prevention lead	There is an interim falls prevention lead in place to coordinate falls improvement work	This creates consistency in improvement work, the ability to apply to a greater range of settings and analyse the impact of improvement.	Falls Prevention Group.	None
Enhanced Care Home Project	A multi-Trust project which focuses on a systems wide approach to falls in dementia patients in care homes. This started in quarter 1 and more detail around improvement will be reported in quarter 2.	This will give the Trust access to greater resources and the ability to co-create projects to address falls risks.	Falls Prevention Group. Physical Health Management Group.	None

Learning from Incidents this Quarter

There are no learning responses related to falls to report on from Quarter 1. There had been local learning reviews requested in the quarter related to falls and these will be reported on in Quarter 2's report.

This reflects the significant improvement work which has occurred for falls incidents as detailed above, which it seems has led to a sustained reduction in falls incidents and a lack of falls incidents leading to serious harm to patients.

Learning from external sources

In the previous quarter, Mersey Care NHS Foundation Trust reported, through NHS England, that concealed knives were being bought onto one of their inpatient wards. A blue light alert was

released to SHSC staff related to this. In Quarter 1, reports of concealed scissors found on wards have been provided from external Trusts, and a similar Blue Light has been disseminated to staff with visuals and advice if there are concerns about concealed blades.

There has also been a high-profile case in the media regarding a London mental health inpatient who, in 2015, sadly took her own life using a plastic bag. The Trust has reviewed inpatient plastic bag usage in light of the details of the case.

- SHSC acute inpatient wards do not use plastic bags in areas accessible to patients unrestricted. This message has been re-iterated.
- In addition, weekly audits have just begun to ensure there are weekly ward checks of plastic bag usage.
- Incident data has been reviewed and provided assurance that there is a very low incidence of patients self-harming using plastic bags. In the main patients have gained access to bags through leave, and this feeds into the work addressed in the restrictive practice section around training and supporting staff confidence around restrictive practice such as searches – while also utilising least restrictive practice.
- There have been no incidents of self-harm with plastic bags in older adult wards. However, work is ongoing with older adult wards to support further reducing access to high-risk plastic items such as Danicentres.

Other Learning

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.

Violence and aggression towards staff remain on an overall downward trajectory, and in the majority remain low or no harm. 6% of incidents were categorised as moderate or above. However, incidents of work-related violence are significant and **can have severe impacts** on mental and physical wellbeing. Most assaults to staff occur on inpatient wards, and improvement work is being targeted towards those areas to support a reduction in incidents.

While not the focus of this report which provides information on key patient safety issues, violence to staff is reported on through the Violence Reduction Oversight group. The Violence Reduction and Prevention strategy is being finalised and will support increased reporting through other avenues in future quarters.

Assaults to patients throughout the Trust remains low and in the main continues to reduce further. However, it is noted there was an increase of patient-to-patient assault in May of this year.

Incident data has been reviewed, and the incidents related to a small number of specific high-risk individuals. Endcliffe experienced a rise in patient-to-patient assaults due to one patient who was very unwell and difficult to de-escalate. The incidents were managed through attempts at de-escalation, continued staff presence in key areas of the ward and increased observations. There is a staff development day planned for Endcliffe in September 2025 which will also support staff to review and learn from incidents.

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. In May there was no increase in

alerts to the local authority, as the safeguarding team were also satisfied with actions put in place to mitigate risk.

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, and to reduce incidents before they occur. Since the previous report, there has been a fast pace of improvement work and new improvements introduced including:

Table 8: Improvement Initiatives Violence and Aggression

Theme	Initiatives/Action
Culture of Care & Staff Support	There is an ongoing assessment of the Trust against Violence & Aggression reduction standards. Culture of Care work is outlining the core commitments to staff wellbeing and safety. This will link in with the review of Violence and Aggression Reduction Standards. Twice daily ward huddles to offer support have been implemented on acute wards. Coproduced incident review process improvements are in place. The new ward will be piloting a trauma informed care model to further support meeting patient needs prior to escalation.
Joint working	Police liaison presence has increased in inpatient areas.
Development & Change	New working group to be set up to review post-incident support. Manager review process on Ulysses has changed to clearly document support. Drafted Violence and Aggression reduction policy awaiting approval. There will be a communication package for new policy. Wards who have experienced significant amounts of incidents, such as Burbage, have changed their post incident review process with patients to good effect.
Data & Reporting	Improve incident recording and reporting – the Trust's action plan is incorporating how this will be improved. Incident reporting is also a key part of Respect Level 3 training to improve staff knowledge.
Roles & Responsibilities	Work is ongoing to clarify responsibilities across all bands and grades regarding workplace safety

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

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.

Learning from Safeguarding Incidents for Quarter 1

Section 42 Enquiries

In Q1, Sheffield City Council caused the Trust to investigate 7 Section 42(2) Enquiries.

Common themes include:

- financial abuse
- unsafe discharge
- 2 linked to Allegations Against Staff.

All 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 **23 allegations** were raised in Q1, with themes including:

- verbal abuse
- staff conduct (inappropriate behaviour)
- breach of confidentiality
- bullying
- medication errors
- domestic abuse

There is linkage within these themes to patient safety priorities (such as medication errors) and ongoing improvement work around risk assessing, care planning and reducing violent and aggressive behaviour which will also support staff to understand their responsibilities and safeguard patients.

Outcomes:

- 8 cases progressed to HR investigation (inc. 1 Section 42 Enquiry)
- 3 Local learning responses (inc. 1 Section 42 Enquiry)
- 2 investigated externally as related to Bank and commissioned service
- 8 cases were NFA (no further action)
- 1 referred to Adult-Local Authority Designated Officer (A-LADO) but subsequently 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. If detailed information is required regarding individual cases, this can be sought from the safeguarding team.

Safeguarding Adult Reviews (SARs) and Information Requests

- In Q1, the Safeguarding Team received **9** requests for information for consideration in SARs—a 43% decrease from Q4.
- We received 1 request for Domestic Abuse Related Death Reviews (DARDR) which related to an Adult Family Violence homicide.

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. This also evidences the need to support staff with clearer risk assessment systems through the personalised assessment of risk project.

Examples of Learning and Action

- Draft Learning Brief for DHR Adult Y has been shared for review. Action plan links to Prevention of Future Deaths. There is learning around:
    - understanding of Adult Family Violence (AFV) - focus appeared to be on intimate partner violence and not AFV. There needs to be consideration of how domestic abuse enquiries are conducted, to ensure staff understand all aspect of domestic abuse, including children and other dependents in the home and parents acting as carers. This will also link in to the improvement work across the Trust regarding risk assessing patients holistically.
    - Whilst in the context of domestic abuse, this learning triangulates with findings from our Safeguarding Adult Concern audit that we need to improve our Think Family model of working.
    - Professional awareness that people with epilepsy have a higher risk of developing Post-ictal Psychosis (PIP) after seizures, which can result in interpersonal violence. Health partners are asked to consider how we implement selective domestic abuse enquiry for individuals diagnosed with epilepsy.
- Learning Brief for SIR13/14/15 is combined due to the sensitive nature of the incidents. Relevant recommendations relate to:

- Promote research that found that the rate of suicide in high-risk high harm perpetrators of domestic abuse is 23 times greater than the highest age-specific suicide rate in the general population. DACT has produced a draft Domestic Abuse Suicide Guidance for Professionals which will be shared with SHSC alongside the learning brief, once approved. This also links to the Suicide Awareness training which addresses key risk factors that increase the likelihood of suicide and has been refreshed to align with new NICE guidelines.

- Develop a working with perpetrators toolkit so that staff can understand the correlation between mental health, substance misuse and perpetrating domestic abuse and include strategies to deal with this. SHSC has already completed a staff questionnaire to understand confidence and has developed bitesize training and tools that will be rolled out in the coming months by the Acting Named Professional Adult Safeguarding. This also links with learning from unexpected deaths, which has highlighted difficulties working with patients who misuse substances and is being acted on through improved training and policies for working with patients with co-morbid substance misuse and mental health difficulties.

Freedom to Speak Up Data in Quarter 1

Freedom to Speak Up provides an alternative route for raising concerns. These recent examples show how speaking up leads to learning and improvements that strengthen safety, fairness, and inclusion.

A concern was raised about a task that required staff working alone for extended periods on wards, which has historically been customary practice. In response, we are reviewing the situation and risk assessments will be carried out for all staff in similar roles. Clear communication with those affected is a priority, and adjustments will be considered to help reduce risks. This will support to maintain safe ward environments, particularly at night, and reduce key risks such as self-harming and violence and aggression.

A member of staff reported experiencing racism. The Guardian provided direct support and ensured the staff member was aware of the options available to them. The individual appreciated this support and felt comfortable with the resolution and the proposed actions. Learning was also identified about how the incident was initially handled, helping to strengthen future responses. The manager connected with the EDI (Equality, Diversity and Inclusion) team, who are leading this work and will provide in-reach support to the team involved. Learning from this case will inform the innovative approach the EDI team is developing to help prevent racism and strengthen support across inpatient areas. This work highlights the importance of alternative routes for staff to speak up and reinforces our commitment to fostering a safe and inclusive culture.

Learning from CQC Data in Quarter 1

In quarter 1 SHSC had 8 received enquiries from the CQC, and themes in relation to patient safety were:

- Individual Patient safety and experience of care
- Whistleblowing in relation to overall care standards in one setting
- Concerns about care delivery

These complaints remain open and will be reported on in subsequent quarters.

Outcomes
SHSC closed 7 of the enquires with the CQC with 1 remaining open as it concerned the care of a patient in a non-SHSC service.

The majority of these relate to older adult's care. One concern related to several bruises a patient received due to being frequently restrained on an older adult ward. While the patient was frequently restrained, this was due to significant concerns for patient and staff safety, and the Respect team were heavily involved in supporting staff in using use of force care plans and in post incident reviews. The patient was body mapped regularly. This does reflect the need, as addressed above in section 4.4, to further support older adult wards with tailored Respect training, however the care provided was comprehensive.

Another closed enquiry related to an older adult care home, with several themes such as inappropriate moving and handling, staffing numbers, medication management and infection prevention control measures, all of which has a risk to patient safety. Unannounced internal visits were conducted which notes areas of good practice in safety measures, personal care, medication management and pressure ulcers. There were areas for improvement which link to patient safety priorities, such as
improvements to falls risk assessment quality, and improvement around this will be reported on in quarter 2.

- risk assessments not always being kept up to date and being quite limited. While immediate action such as record keeping training was put in place in the service, the PAR project, when rolled out to Birch, will address this learning systematically.
- care plans containing standard statements that are not resident centred. The back-to-basics action plan includes care plan training which will address this learning.

A rapid action plan was put in place which assured the CQC.

The CQC also carried out 2 inspections in May of 2 wards, Burbage and Stanage. Both inspections noted good practice around compassionate patient care (which is one of the key improvement points around self-harm and restrictive practice addressed above) and supportive facilities. There was noted learning around reviewing care plans and risk assessments, which will form part of the improvement actions described earlier in the report.

Learning from Complaints – Quarter 1

During Quarter 1, the Trust received 40 formal complaints, an increase in 12 from quarter 4 2024/25. Note – in quarter 3 2024/25 38 complaints were received.

Top Complaint Themes:

- **Access to care** – 10 complaints
- **Values and Behaviours** – 6 complaints
- **Communication** – 6 complaints

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

- **Improving ease of access to Sheffield Talking therapy groups and ensuring these are not disrupted by technical problems**: A number of actions were taken, including adding a read receipt for first time users to ensure they have been able to access their link prior to the session.

- **Agreement to provide written guidance on executive dysfunction.** The Sheffield Adult Autism and Neurodevelopmental Service will provide written guidance on this to help address potential confusion about this subject. This will support learning reported on in this quarter, and previous quarters, regarding providing care that meets neurodiverse needs in both inpatient and community settings.

- **Review of signage on Burbage.** This is to ensure that patients on the ward can see what staff on shift have been allocated as their contact nurse. This will support consistency in care, and information sharing which will empower patients. This links to relationship based and trauma informed care as addressed within this report, particularly around reducing incidents of self-harm and violence.

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.

- There are currently 11 open learning reviews (complaints closed up until 30 June 2025).

Summary Triangulated Learning Themes and Improvement Across the Report

In alignment with the Patient Safety Incident Response Framework (PSIRF), the analysis of learning from a range of sources enables focussed quality improvement activity to improve safety.
The following themes are evident through triangulation

i. Risk Assessment
Sources:
- Unexpected deaths
- Self-harm incidents
- Safeguarding Adult Reviews
- Complaints and CQC feedback

Key Learning:
- Risk assessments are often not personalised or holistic.
- Staff lack confidence in managing complex risk scenarios.
- Risk documentation is inconsistent across services.

Improvement Actions:
- Rollout of the **Personalised Assessment of Risk (PAR)** tool.
- Training and audit programmes to improve care planning.
- Integration into safeguarding and Think Family approaches.

ii. Substance Misuse and Dual Diagnosis

Sources:
- Unexpected deaths
- Safeguarding Adult Reviews
- Domestic abuse-related learning briefs

Key Learning:
- Staff report low confidence in managing co-morbid substance misuse and mental health.
- Joint care planning with external services is inconsistent.
- Substance misuse is a contributing factor in fire-related incidents and interpersonal violence.

Improvement Actions:
- Drafted **Dual Diagnosis Policy** and joint working groups with Likewise.
- Development of **Working with Perpetrators Toolkit**.
- Training modules to support staff confidence and competence.

ii. Discharge and Transfer Safety
Sources:
- Section 42 Enquiries
- Medication errors
- Unexpected deaths
- Complaints

Key Learning:
- Unsafe or poorly coordinated discharges from acute trusts to SHSC services.
- Lack of clarity around roles and responsibilities during transfers.
- Medication needs and physical health risks not always communicated.

Improvement Actions:
- New discharge process piloted with Sheffield Teaching Hospitals.
- Role guides and interoperable systems being scoped.
- Revised oxygen prescribing policy and improved handover protocols.

iv. Domestic Abuse and Family Violence
Sources:
- Safeguarding Adult Reviews
- DARDR
- Learning briefs (Adult Y, SIR13/14/15)
- Unexpected deaths

Key Learning:
- Narrow focus on intimate partner violence; AFV often overlooked.
- Need for selective enquiry in epilepsy and other high-risk conditions.
- Suicide risk in high-harm perpetrators is significantly elevated.

Improvement Actions:
- Broadened domestic abuse enquiry protocols.
- Suicide Awareness Training aligned with NICE guidelines.
- Development of Domestic Abuse Suicide Guidance and toolkit.

v. Staff Confidence and Culture
Sources:
- Allegations Against Staff
- Restrictive Practice incidents
- Freedom to Speak Up
- Complaints

Key Learning:
- Staff confidence impacts incident management and reporting.
- Cultural factors influence use of restrictive practices and trauma-informed care.
- Racism and bullying incidents highlight gaps in inclusive practice.

Improvement Actions:
- Respect training revised to include neurodiversity and trauma-informed modules.
- Culture of Care initiatives and ward-based support.
- EDI team in-reach and staff wellbeing programmes.

vi. Information Sharing and Digital Integration
Sources:
- Unexpected deaths
- Medication errors

- Self-harm incidents
- Safeguarding

Key Learning:

- Disjointed digital platforms hinder timely information sharing.
- Lack of access to systems like SystemOne and Summary Care Records.
- Incomplete or inaccessible records contribute to safety risks.

Improvement Actions:

- Integration of Rio and Iaptus underway; SystemOne integration being explored.
- Raised concerns at Area Prescribing Groups.
- Shared learning across healthcare groups.

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 have established a dedicated Learning and Improvement Group. This group plays a pivotal role in overseeing the delivery of improvement initiatives that are directly aligned with our identified patient safety priorities.

The first of these meetings has been held and addressed all 5 patient safety priorities, consolidating the improvement work and confirming leads. The meeting also bought together learning from LeDer reviews and learning responses including structured judgement reviews, to ensure that improvement actions are joined up and address the range of learning identified throughout these reviews.

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

Recommendations

The Board of Directors is asked to:

- **Receive assurance** that the Trust maintains a strong incident reporting culture, evidenced by consistently high levels of reporting, particularly of near-miss, negligible, and low-harm incidents reflecting openness and a proactive approach to safety.
- **Endorse the continued strategic focus** on the five patient safety priorities:
  Unexpected deaths, self-harm, medication errors, restrictive practice, and falls,
  and support the improvement initiatives underway to address these areas through targeted quality improvement and governance oversight.
- **Receive assurance** that the Trust is effectively triangulating learning across multiple sources including incidents, safeguarding, complaints, Freedom to Speak Up, and external reviews to identify key safety themes and drive coordinated, system-wide improvement.

Appendix 1

Data sets/ SPC charts

Figure 1: Expected Deaths 01/07/2023 – 30/06/2025

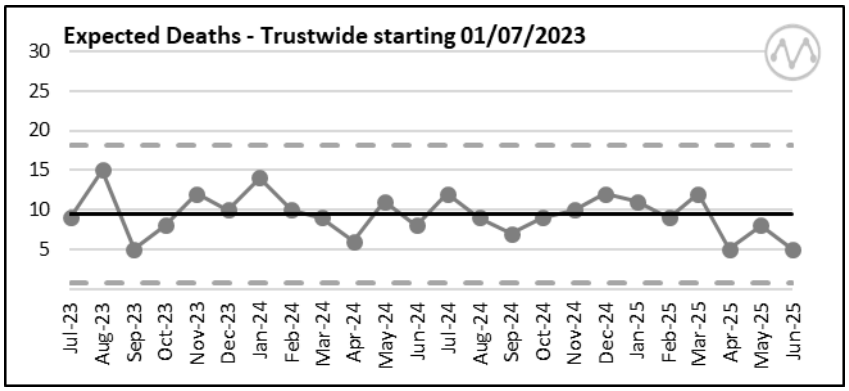


Figure 2: Unexpected Deaths 01/07/2023 – 30/06/2025

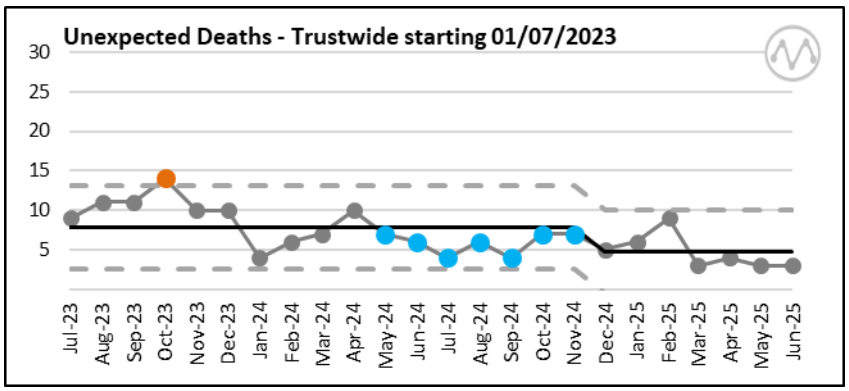


Figure 3: Service User Ethnicity for all Deaths 01/04/2023 – 31/03/2025

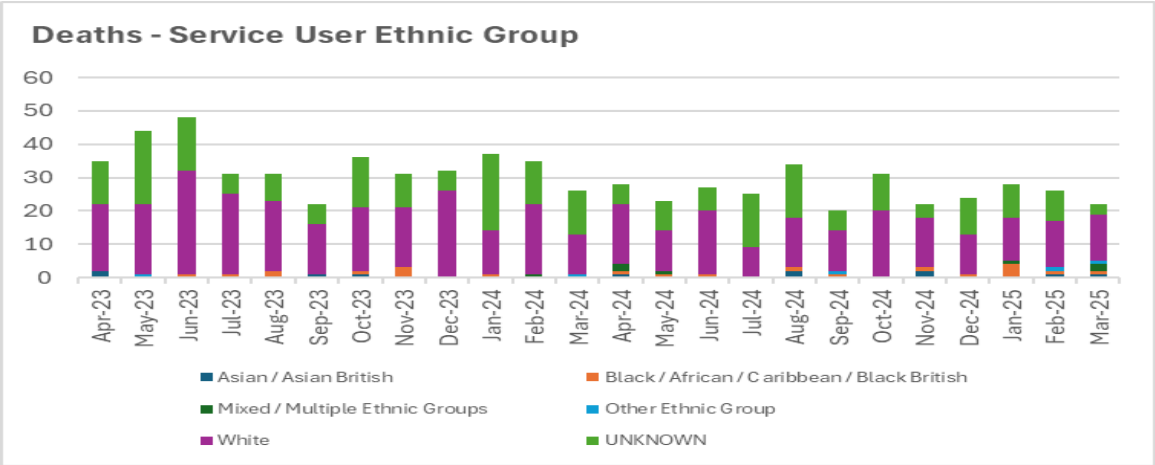


Figure 4: Suspected Suicides 01/07/2023 – 30/06/2025

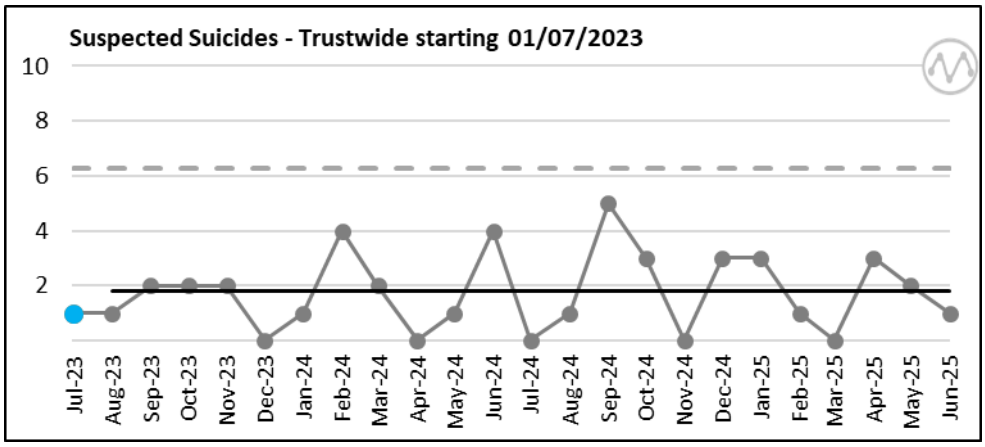


Figure 5: Self-harm incidents 01/07/2023 – 30/06/2025

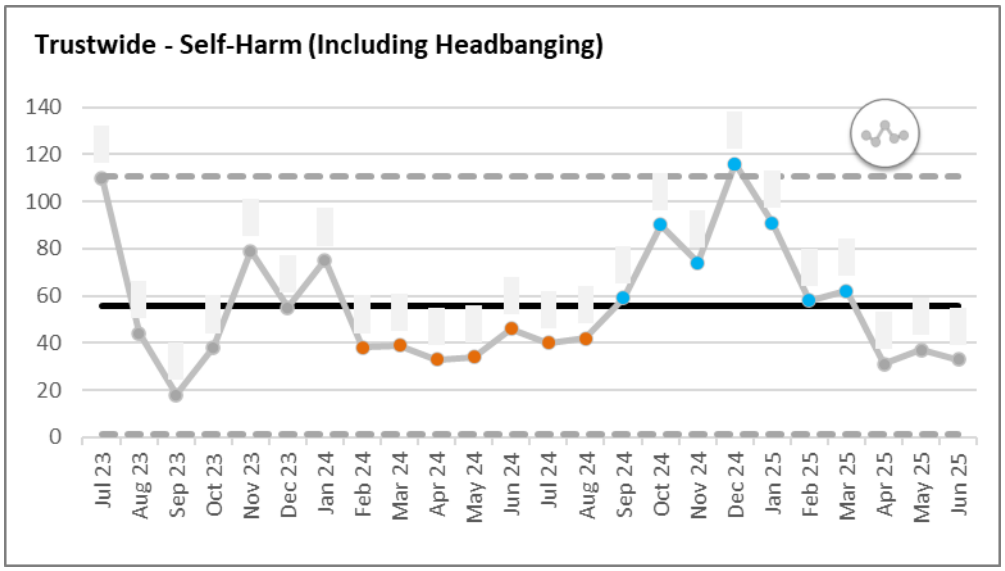


Figure 6: Self harm incidents in Q1 by Team

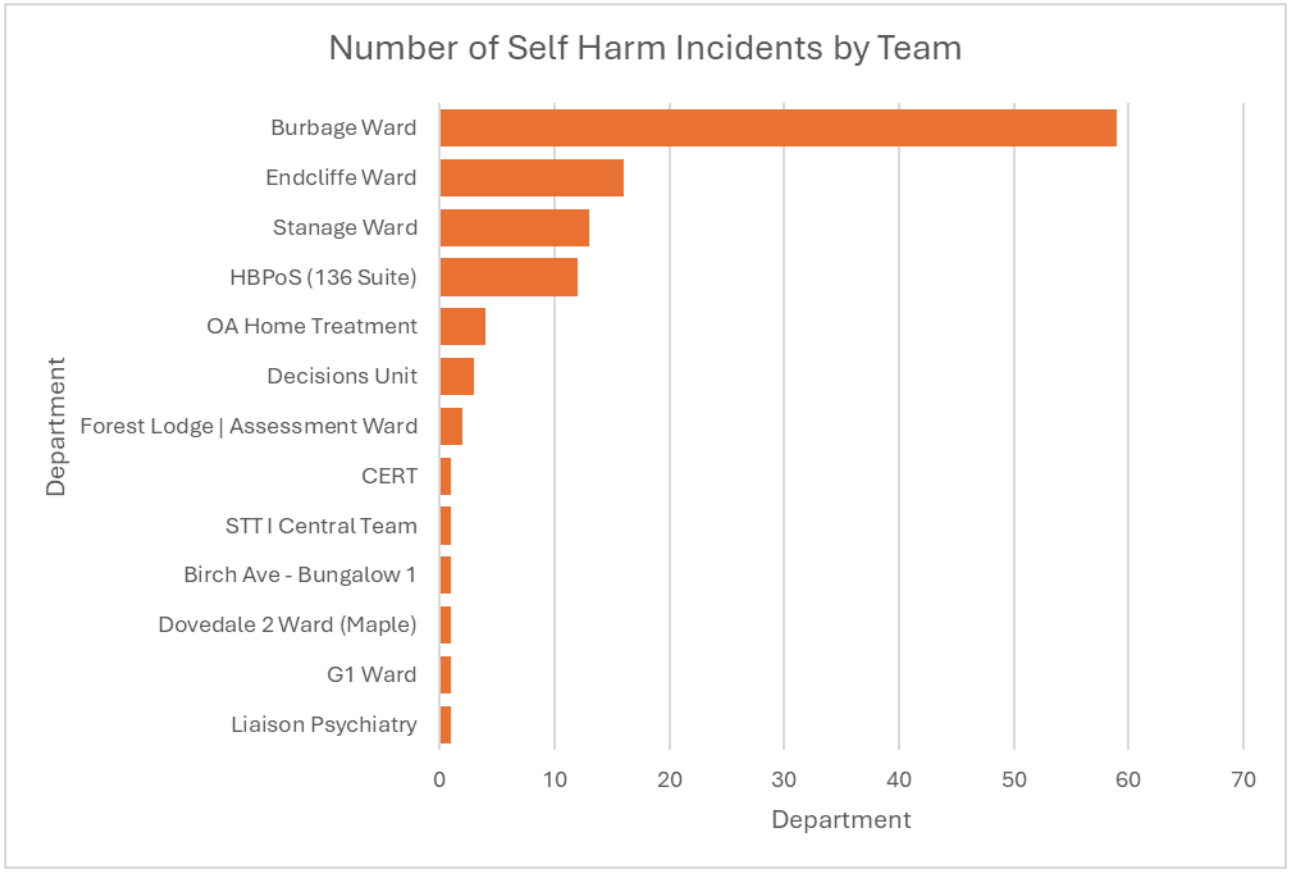


Figure 7: Self-harm incidents by Service User Ethnicity 01/04/2023 – 31/03/2025

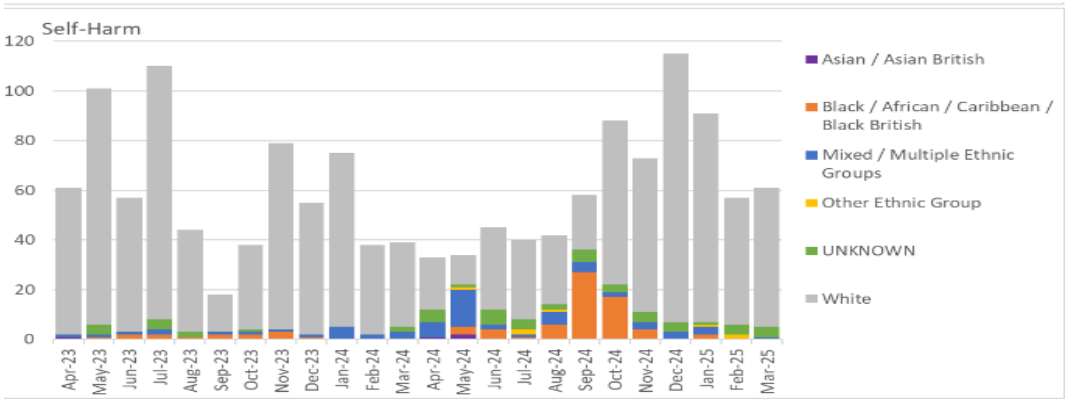


Figure 8: Self-harm incidents by Actual Impact

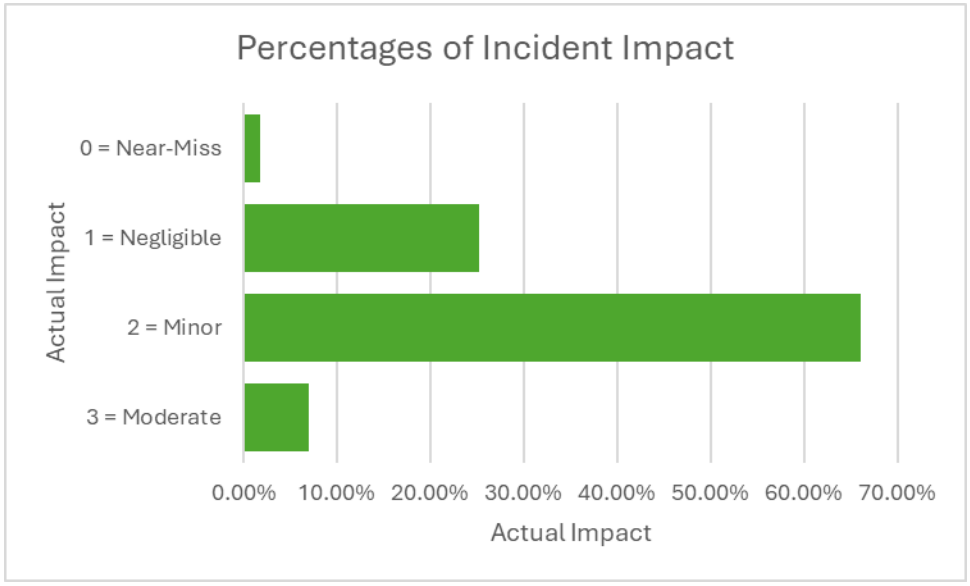


Figure 9: Medication Incidents 01/0472023 – 30/06/2025

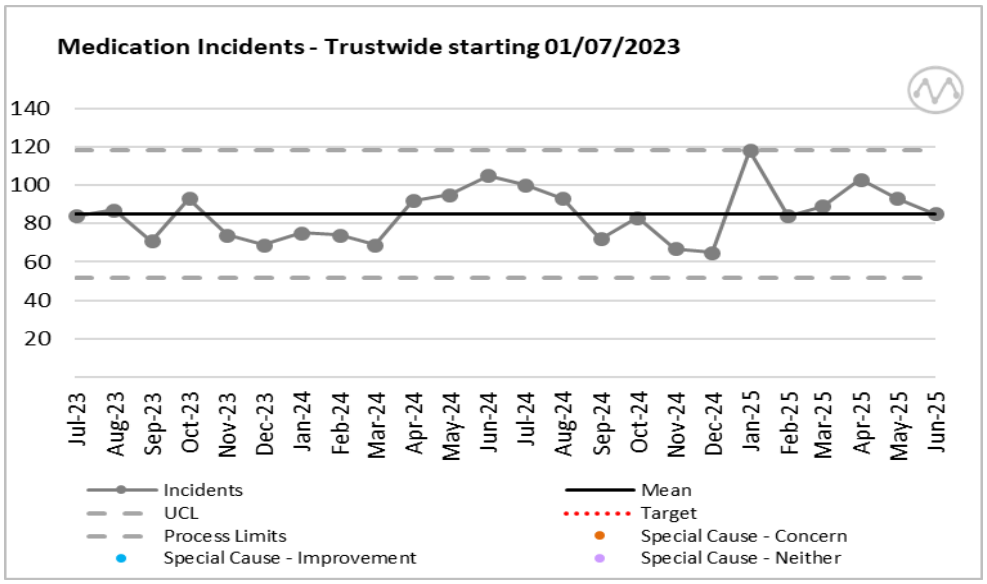


Figure 10: Medication Incidents broken down by type 01/07/2023 – 30/06/2025

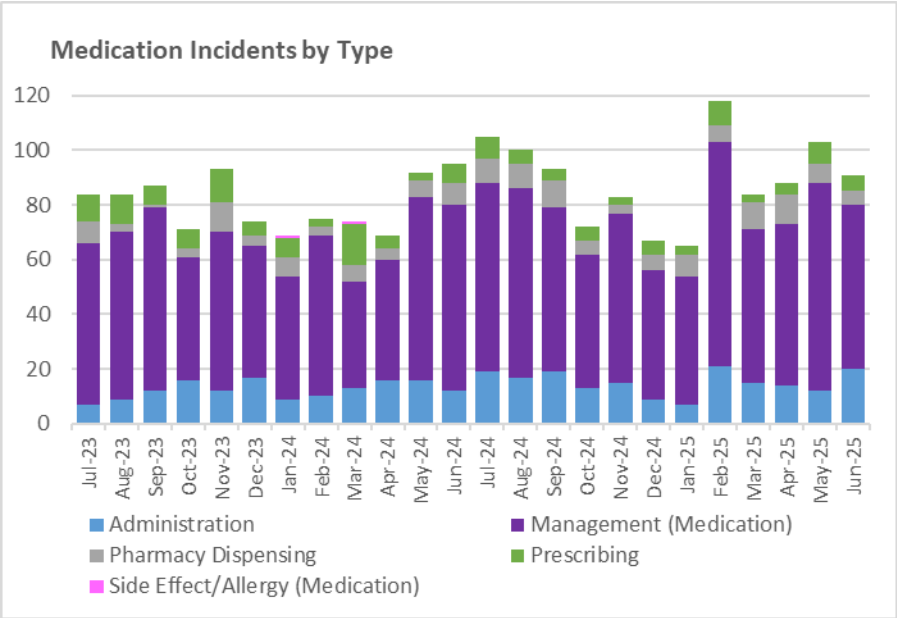


Figure 11: Physical Restraint Incidents 01/07/2023 – 30/06/2025

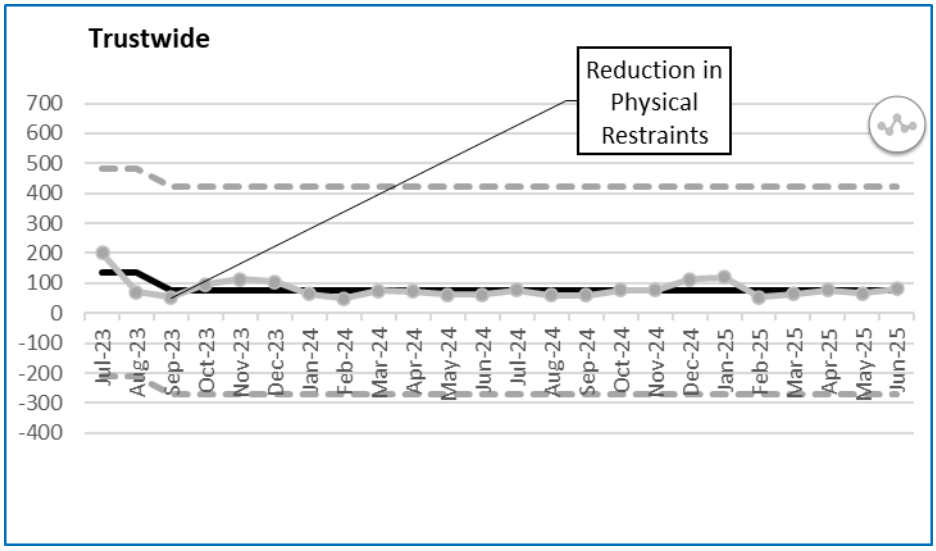


Figure 12: Rapid tranquilisation Incidents 01/07/2023 – 30/06/2025

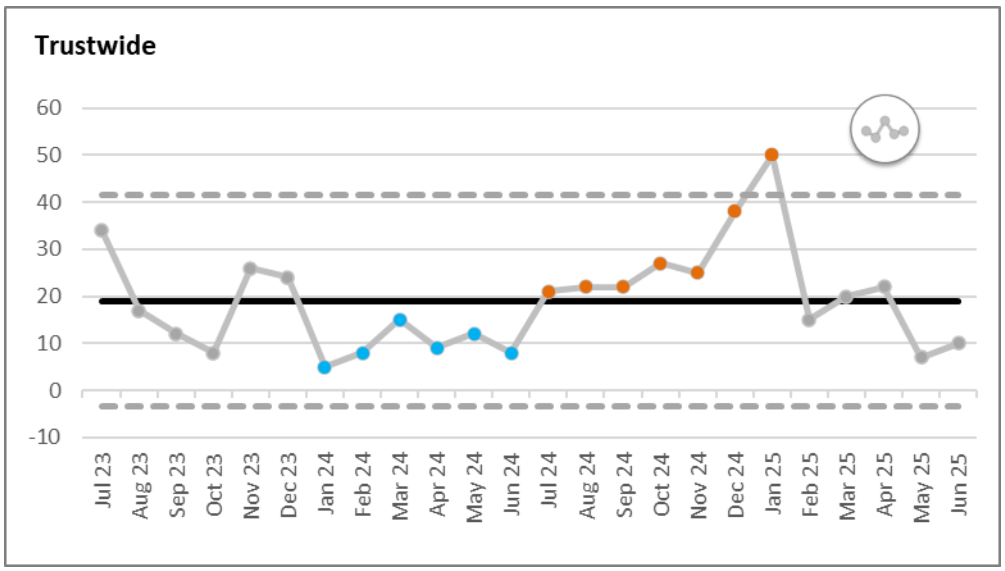


Figure 13: Seclusion Episodes 01/07/2023 – 30/06/2025

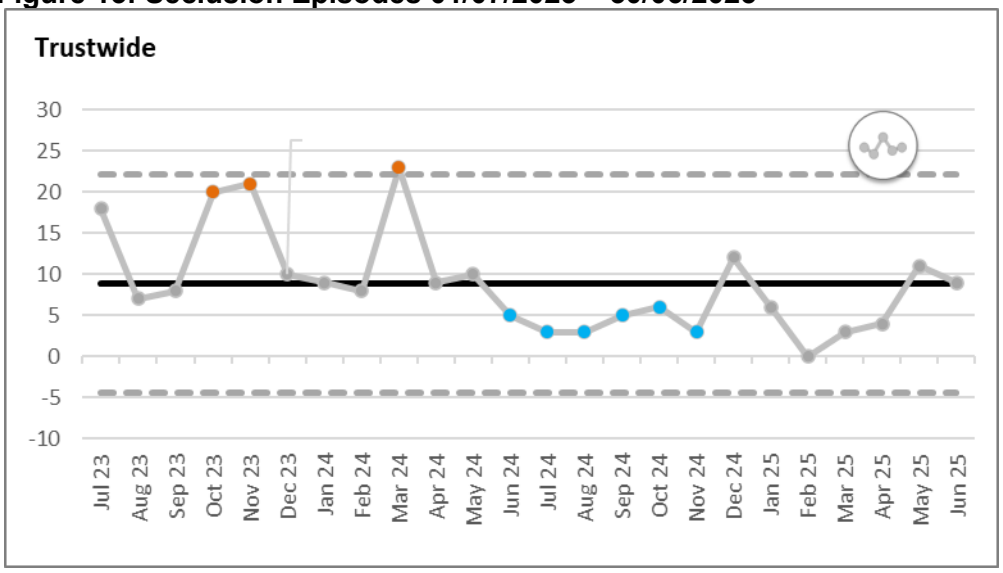


Figure 14: Falls Incidents 01/07/2023 – 30/06/2025

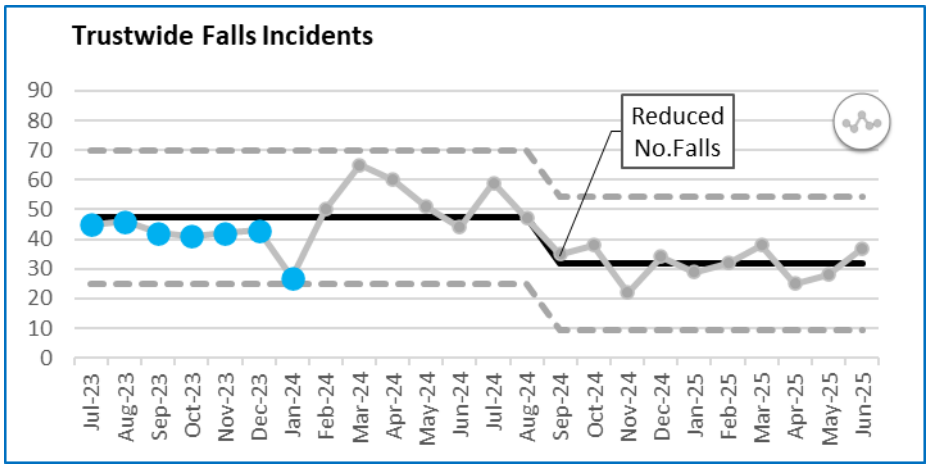


Figure 15: Staff Assaults across the Trust from July 2023

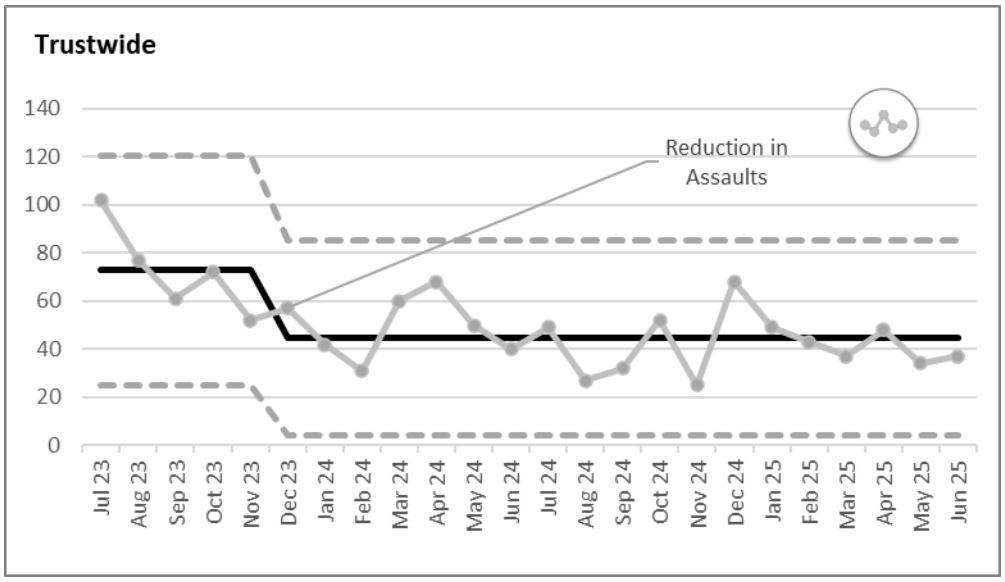


Figure 16: Patient Assaults across the Trust from July 2023