NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Learning from incidents

2024/2025

Patient Safety Support Team

June 2025

With **all of us** in mind.

Our headlines

- 16,070 incidents reported (6.1% increase on 2023/24) excluding Cheswold Park Hospital data
- 96% of incidents resulted in no/low harm
- No Never Events
- High reporting rate with high proportion of no/low harm is indicative of a positive safety culture
- Cheswold Park Hospital joined the Trust from 1 October 2024. Note data for Cheswold Park is currently reported separately.

Patient Safety Incident Response Framework (PSIRF)

The Trust transitioned to working under the Patient Safety Incident Response Framework (PSIRF) from 1 December 2023.

During 2024/25 we have been working with the PSIRF policy and procedures we developed ahead of going live with PSIRF in December 2023. We have:

- Developed learning response resources and supported care groups to facilitate learning responses.
- Held patient safety oversight group and developed care group meetings to support processes.
- Reflected on how we were working in practice against what we imagined we would do – this information is feeding into our review.

Next Steps

- A review is now underway to reflect on what has worked well and where we can improve going forward. This will include a review of our PSIRF plan.
- Reflections from those involved will be included in the review.
- Policies and procedures will be updated to reflect changes.

Search for PSIRF on the intranet

PSIRF Learning Responses

Below is a summary of our learning response methods with each one being explained in greater detail below:

Learning responses for assessing if a response is required

(used to help understand if we need to know more or if it fits with improvement work)

- Manager's 48-hour rapid review
- Case note review
- Structured Judgement Review (deaths only)

Learning response to inform improvement and to understand more

(where contributory factors are not well understood/improvement work is minimal)

- Debrief
- After action review
- Specialist learning review
- Patient Safety Incident Investigation

Learning response for improvement based on known issues or existing improvement work

(use existing information to improve knowledge about links, themes and barriers)

- Retrospective thematic analysis

Search for Learning Responses on the Intranet

Manager's 48 hour 'rapid' review

A Manager's 48-hour rapid review is completed on Datix for certain incidents. It is a first stage case note review which is completed by the reviewing manager.

- Training is provided monthly by the PSST for all managers who complete 48 hr reviews.
- The rapid review provides a means to assess and accept a first stage case note review. It provides an opportunity to agree if there could be further potential learning to be identified.
- This review continues to be vital to understand if there are any issues for further exploration. Where this is the case a further learning response will be agreed.

Debrief

A Debrief is a team-based discussion initiated as soon as possible after an incident with staff involved to ensure continued safety and support needs are met.

- Teams are conducting various forms of debrief for different purposes wider than PSIRF, from staff reflections of practice and safety huddles, to psychological facilitated debriefs.
- Debriefs have been a popular PSIRF learning response, and as PSIRF continues to evolve the debrief process will adapt and be refined further, particularly with the use of language, support, and learning.

Debrief themes

Debrief completed within Early Interventions community team following the death of a service user

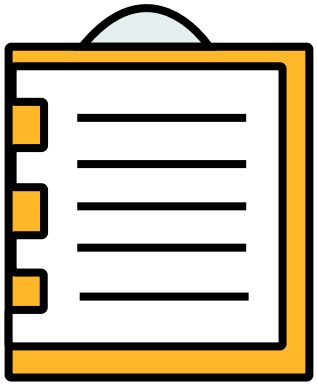
Debriefs have involved staff directly and indirectly affected by the incident

Common themes have found the process:

- Gives staff time and space to stop and reflect
- Ensure staff wellbeing is checked and support arranged
- Ensure FLO is linked if indicated

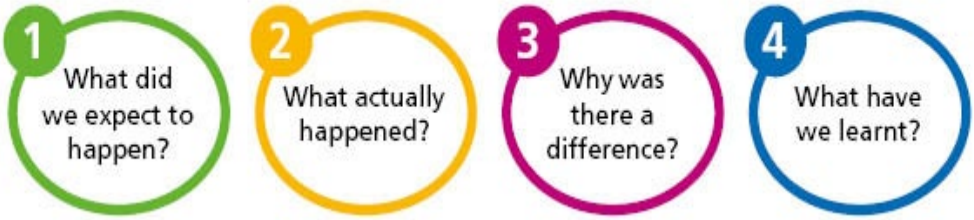
Learning points noted from above incidents:

- Understanding and reflecting on the incident enables reflection on individual and team processes around record keeping
- Manager and lead clinician contact with the family face-to-face following the death was well received
- Involvement and engagement from FLO to help signpost for support for young family members and those who live further afield
- Ensuring that information sharing packs for families have full contact details and direct to duty in staff absence



After Action Review - development

An after action review is a team based facilitated discussion of an incident which gives individuals involved the ability to reflect on and contribute to the understanding about what happened for learning



- Overall staff have found this form of structured debrief very helpful to discuss at length with professionals from other teams coming together to reflect on care provided and what could be changed to improve this. A challenge has been where there are joint learning responses with external organisations.
- The national PSIRF template was developed part way through the year and commenced in use to document reviews: this will be adapted further to suit the needs of the Trust governance processes.

After Action Review example

A patient under the services of the Community Neighbourhood Nursing Team was not administered their long acting insulin, only the short acting insulin had been administered and the patient was unwell with elevated blood sugar the following morning and had been transferred to hospital for assessment.

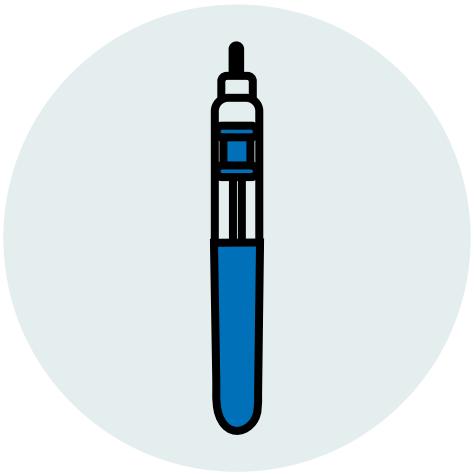
The after action review involved face to face meeting with staff impacted by the incident

We learned that…

- There was no planned referral, and the doses initially were put in place by the patient's wife who had been 'carbohydrate counting'
- There was no oversight of dosage available over the weekend by the diabetes service or the patient's GP therefore out of hours GP had to be utilised to support the district nurse

We found that…

- There was ongoing work to look at the number of diabetes regimes being managed by the service and their complexity to understand demand
- There needed to be consideration for additional equipment – pumps
- To improve communication with diabetes service – consideration for link workers and/or forums to discuss complex cases/interface issues, consider inviting to the integrated team meetings
- Realistic and collaborative planning prior to district nurse involvement which includes agreements between the care home and the district nurses
- There is a need to improve relationships with care homes in the area
- Consideration around community matron support over the weekend
- Availability of advice on changing regimes and consideration of the upskilling of our own workforce to support this
- Review NNS criteria with this incident in mind – specifically admissions for respite where patients are complex. Is a more boundaried criteria required?



Specialist learning review

A specialist learning review is used to identify learning from multiple patient safety incidents and explore a safety theme, pathway and process

- Gaining feedback forms after the event does prove challenging and so asking for feedback at the time would be advantageous. The majority of people in attendance report some positives from the experience, there are still some difficulties in adapting to the changes and ensuring staff fully understand the process – managing expectations of large numbers of people, ensuring all have a voice and systems analysis is championed in the experience remains of importance.
- Where there is discussion on areas of learning it is important to consider if an action should be documented and carried into an action plan in Datix to map better outcomes and any solutions created.
- A new and revised approach to sharing updates and learning from patient safety related incidents would be an advantage, staff report not always being aware of the release of learning summaries.

Specialist learning review example (Web173542)

Incidents involving a number of community patient deaths in one community mental health team

The specialist learning review involved 18 team members – an opportunity to briefly reflect on the person known to them and the understanding on the areas of challenge or difficulties faced by individuals and the team

We found themes relating to:

1. Drugs and Alcohol
2. Engagement difficulties
3. Inter-team/Inter-organisational working

We learned that:

- Where inter-team difficulties arise on transfer of care, the MDT/FACT approach may help in guiding decision making and escalation on disagreements for care pathways
- Staff may not always be aware of sources of help and support available to them

We learned that:

- Commissioning arrangements for TIPD specialists in Wakefield are different to other parts of the Trust.
- Dual diagnosis specialist practitioners are not embedded in the teams – individuals will take on the role but without the additional training.
- Where co-existing needs are apparent this can prevent access to specialist treatment for ASD or ADHD.
- Existing improvement works are a shared platform for learning and improving Trust-wide.

Patient Safety Incident Investigation (PSII)

An in-depth systems analysis review of specific patient safety incidents which are defined in the Trust's Patient Safety Incident Response Plan. Led by patient safety support team

- There are three PSIIs underway in the new PSII process, however they are ongoing. The amount of PSIIs in comparison to previous years' SIs reflects that we are selecting incidents based on proportionate learning and resource (which is one of the key aims of PSIRF).
- There are known difficulties with timing of completion/approval of PSIIs, which will be reviewed throughout the next year.

Patient Safety Incident thematic review project

Clinical risk assessment (FIRM)

This project was identified through PSIRF as an improvement project because of the number of Serious Incident actions related to FIRM risk assessment. However, there has been separate work underway around care planning and risk assessment, with the primary focus being on care planning and embedding risk assessment more robustly into that process. Work was also undertaken to develop a generic audit tool; however, it didn't appear to have been embedded in practice. To avoid duplication of work, the project lead held some initial meetings to explore further with staff. A survey was developed with the aim of seeking an understanding of frontline colleagues' experience of FIRM in practice, including the barriers and reflections; 72 responses were received. Analysis of the results and learning has given a deeper understanding of insights. A report concluding the work has been shared with the Care Planning and Risk Assessment working group, this has been closed at the Patient Safety Improvement Group.

Pressure ulcer clinical documentation in Barnsley Physical Health & Wellbeing Care Group

This thematic project arose through analysis of Serious Incident actions over a number of years, which could be related back to pressure ulcer clinical documentation. The work involved a group process mapping day which took place on the 6 November 2024. The day involved front line clinicians, team leaders, managers, specialists, SystmOne, data and patient safety specialists.

We learned that…

- The use of care plans required review for scheduling and allocation of work, and that a new wound care template on SystmOne would support consolidation of all existing wound care documentation. This aims to reduce time and duplication of work by creating leaner effective systems for documentation and eliminate the need for routine Datix reports for each pressure ulcer and the time taken to process each incident report. It is hoped the template will improve the personalisation of care and see improved quality documentation.

Next steps…

- A report has been drafted and outputs from the day are being taken forward in a task and finish improvement group within Barnsley Physical Health and Wellbeing Care Group.

Inpatient suicide and self harm

The thematic work involved the review of all historical incidents of inpatient apparent suicides. Due to delays in completion, it was agreed that 2024 data of apparent inpatient suicides would also be included

- Two multi-professional meetings have taken place. Lines of enquiry have been established
- A Task and Finish group work stream identified for self-injury inclusive of partners (wound management)
- Culture of care (RcPsych works) learnings to extract
- NHSE keeping safe from suicide guidance released April 25

We learned that:

- Report is in preparation
- Several areas identified in the routine enquiry cross over improvement works already established
- Examples of best practice/excellence in practice should be shared wider

Next steps…

- Draft report when ready to be shared for review

Patient Safety Incident thematic desk top review

Rail related deaths

A review of a cluster of deaths that had occurred over a 12 months period across the Trust on rail lines was completed. A desk top analysis of the clinical records was completed and the findings collated. The information shared highlighted:

- Incidents occurred at smaller train stations where there may be easier access to train lines and potentially less observation/intervention by railway staff or the public.
- Neurodiversity was present in 3 of the 6 cases reviewed. People had either had a formal diagnosis of Autism or Attention Deficit Hyperactivity Disorder (ADHD), had been referred for assessment or care teams had queried undiagnosed ASD/ADHD. Present research suggests a lifetime prevalence of suicidal ideation in autistic adults ranges between 19.7% and 66%, and suicide attempts between 1.8% and 36%, the highest prevalence estimates being in late-diagnosed adults. Self-reported autistic traits in those without autism diagnoses are also associated with increased risk of suicidal thoughts and behaviours (Cassidy, 2020).
- 2 out of the 6 cases had recently been discharged due to non-engagement.
- There was potential diagnostic overshadowing in 4 out of the 6 cases.
- There was evidence of current or historical risk of abuse or suspected history of abuse in 3 out of the 6 cases.

Areas to consider for learning:

Whilst the deaths related to individual people and their own individual circumstances the review provided the opportunity to share learning. Some of the key themes that emerged present wider opportunities to enhance risk assessment and management and could present across a number of incident types therefore actions are shared wider to maximise impact of learning

- Working closely with partner organisations on near real-time information sharing on apparent suicides
- Increased review on diagnosis for ASD and ADHD
- Increased understanding on the risk for non-engagement, knowledge sharing to inform policy and guidance
- Identifying and responding to incidence of abuse and understanding the impact

We learned that:

- Improvement workstreams are already in place and the paper will be shared to inform developments
- Increased involvement from specialist evaluation on apparent suicides where ASD or ADHD is questioned or confirmed

Next steps:

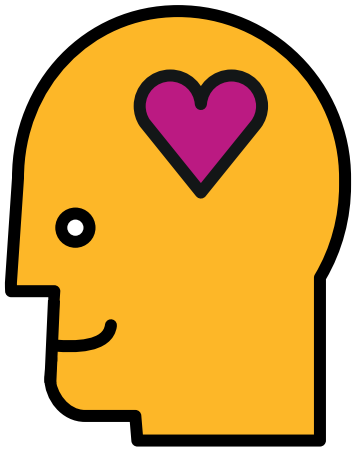
- Paper shared to care groups for review

Mental Health Inpatient Care Group

- Weekly incident monitoring groups are well established and run independently. Dashboards have been created to enable review of amber and red incidents. Cluster incidents lower in other colour coding reviewed, incidents are being linked in the background to aid review.
- Learning has been identified on the barriers apparent for inter-team communications and transfers of service users in a timely manner. Some positive examples in other areas where teams have been working with highly complex and unpredictable service user risks, demonstrate multi-agency, partnership working across local authorities and with local police to support management and mitigation of risks. Effective care planning with the inclusion and presence of patient safety representative and/or other directorate specialists which have enhanced team supported decision making, care planning and risk management.
- Following a case note review completed, a contrasting situation was noted on responses from IHBTT teams when service users are calling on several occasions for support but this is not activated at the time of the calls – there is learning in ensuring that relapse plans are explored and that involvement of family or another trusted person is explored in ensuring safety plans are stable and being followed.
- An amber IHBTT incident had raised a query over whether assessment of risk to suicide in someone with ASD needs a more direct approach, although not a suggested area of learning as there was no direct cause and effect this individual factor did raise internal team discussion
- There was learning identified following the death of a community service user through suicide, the review identified the need for early care planning at the point of transition

from inpatient services. There are existing improvement workstreams in place to improve clinical record keeping standards, care planning and safety planning.

- In some cases where there has been a deterioration in service user health which had been felt to contribute to difficult or challenging patient presentation leading to incidents, the reviews have identified areas where a more assertive approach to engagement with mental health teams may have been of benefit. Work is ongoing on care planning and safety planning Trust-wide, new keeping safe and keeping well plans are now in use that ensure a personalised approach and identified supportive other engagement.
- There have been a number of incidents relating to self-harm or death where the theme emerging from manager rapid reviews are identifying challenges with co-existing substance misuse. Noted learnings and actions captured within review on improving partner organisation working and, where possible, presence of Specialist Dual Diagnosis leads in key meetings to guide on care and risk management.
- There was learning noted within one incident as to the awareness of staff and teams on the support that can be provided for gambling harms – gam care. This local level learning was shared within the team.
- Within one community team a theme on reporting safeguarding concerns in adults had been noted/ improving knowledge, adding to Datix and follow up on outcomes were noted as areas of learning.
- For another community team it was noted their main concern was to engage with the service user, which led to delay in referring to PIPOT and the Safeguarding team. Learning identified that raising concerns must be prioritised over concerns around therapeutic rupture.
- There have been considerations as to whether there were missed opportunities to conduct further face-to-race assessments/visits to establish potential risks and to improve clinical decision making.
- There was learning identified following a violence and aggressive incident whilst an IHBTT team were conducting a home visit. Staff did not have their lone working device on with them to use, to alert police quickly. Following this, the team reflected how unpredictable IHBTT work can be and started to use their lone worker devices.



Children, Young People and Families Care Group

Themes and trends/Local Improvement Work

Patient safety service improvement plan has been developed for all CAMHS services to provide evidence and assurance against. The plan has actions to be undertaken over a six-monthly period, and is not limited to:

- Sustained use of the Consent tool & ensuring the child is consulted about the care and discharge
- Recording if a child was seen alone
- Discharge planning and letters being addressed to the person
- FIRM risk assessment

IG incidents across community CAMHS led to a briefing being shared with the teams via CAMHS CGG. All services provided assurance against the points of learning.

- CAMHS have implemented a service wide PSOG and local PSOGs to discuss and agree incidents and a range of learning responses, which are subsequently managed timely in completion and actions for improvement are identified.

Themes and trends – lower-level incidents

- Staff experience verbal aggression, often by telephone and often associated with waiting times. A piece of work is underway to develop a letter to families around verbal aggression and the support of customer services will be sought.
- To consider the reporting of self-harm in community settings as the agenda for suicide prevention develops to establish patterns of escalating risk.

Areas of concerns/risks

- More recently Datix staffing levels and demand in Crisis & Eating Disorder teams has led to the Risk Register severity rating being increased.
- Increased Datix under category of Care Pathways associated with capacity and demand.
- There have been delays in taking forward repeated learning that requires Trust level guidance, and this gives rise to concern given the re-occurring themes e.g. medical Care plan standards/FIRM guidance.

Learning identified

- Continued SBARs shared with staff (see Learning Library slides).
- There is an SBAR underway evaluating the level of information being shared with a school following an IG breach where there was information sent to an incorrect school which has led to secondary considerations about the custom and practice of sending full reports to schools.
- Following an audit of discharge letters, work has been undertaken to develop letters and ensure the voice of the child is sought, considered and documented in consultation pathways (and the use of FIRM risk assessment on these pathways).
- An SBAR was drafted (in collaboration with the staff member) following threats of harm to a member of staff and the support plan included Trust security staff who were very helpful. Staff were reminded to submit Datix.

Learning responses being used

- 48-hour rapid reviews
- Debrief – are not always completed, highlighting a potential need to progress this over the next year.
- After actions reviews
- Weekly learning from Team PSOGs

Forensic Services Care Group

Themes and trends

- Quality of observation and engagement, and a QI project has been initiated linking with Cheswold with similar incidents
- Policy and practice
- Environment and security
- Violence and aggression
- Physical illness

Areas of concerns/risks

- Observation & engagement, environment and security

Learning identified

- The importance of monitoring mental state and ensuring adequate staffing on all areas of the wards.
- Awareness of the risks that cannot always be predicted or expected whilst a patient is accessing leave.
- Better understanding of the support available from specialist advisers in the safeguarding team.
- There are ongoing challenges around RCRP and navigating recalls with support in the community when presenting circumstances are risky to staff.
- Ensuring seclusion checks are completed regularly, to check for damage.
- Importance of communication between professional network and sharing of information.
- Staff need to remain vigilant and ensure care plans/risk handover are up-to-date to ensure all staff are aware of his current risk.
- The team have reflected on how to keep themselves safe and reviewed the lone worker responsibilities and care plans. This includes where visits take place, lone worker instructions and clear care planning.

Local improvement work

- Bluelight development, debrief sessions, action plan & quality improvement work, including Dip samples to improve awareness and implementation of policy.

Learning responses being used

- 48hr rapid review
- Debrief, planned quality improvement work
- Sharing learning through Bluelight alerts

Learning Disability and ASD/ADHD Care Group

Themes and trends

- Violence and aggression (physical contact made and aggressive episodes, mainly at Horizon centre).
- Medication
- Information Governance
- Deaths reported to LeDeR

Areas of concerns/risks

- Injuries following restraints
- Transitions in care

Learning identified

- Environmental factors in relation to location of restraints within the Horizon centre (limited space).
- Availability and use of PPE bite jackets and hand protectors at the Horizon centre.
- Gender requests for more male staff to cover bank shifts at Horizon centre.
- To communicate more widely (within the team – to relevant professionals) the risks and mitigating strategies that would be helpful to clients with known risks when attending appointments; and that when someone is coming in for outpatient appointments with known challenging behaviours the team should make a plan regarding proactive and reactive risk management strategies to support the clinic to ensure best possible outcomes.
- The importance of risk assessments and reviewing patients in their home setting as well as day care.
- The importance of sharing information between colleagues and with external agencies.
- Timely communication within teams in relation to sharing information e.g. safeguarding referrals, to avoid delay.
- Being proactive with using information gained from out of area services in relation to clients.
- Lone working devices are used and switched on during home visits.

Local improvement work

- Transitions in care through MDT meetings between services to identify and manage presenting risk.
- Completion of risk assessments and MDT support.
- To improve working relationships with mainstream mental health services for supporting clients with personality disorders.
- Gender requests for more male staff to cover bank shifts at Horizon.

Learning responses being used

- 48-hour rapid reviews and debrief (safety huddle).

Barnsley Physical Health & Wellbeing Care Group

Themes and trends

- Category 3 pressure ulcers are the highest reported type of incident.
- The highest number of incidents are reported by the Neighbourhood Nursing Service (NNS) due to reporting of pressure ulcers.

Areas of concerns/risks

To focus on increasing the reporting of low-level safeguarding concerns.

A system in place to ensure safeguarding referrals relating to care homes are monitored, this will be further developed going forward. Staff are attending regular safeguarding supervision sessions. A monthly meeting has been established with adult safeguarding team in the local authority to improve communication and the quality of reporting of safeguarding concerns and referrals. A survey monkey has been developed to identify any learning needs of staff making referrals and training sessions are being organised.

Learning identified

- Foot Wound pathway for NNS/Podiatry has been updated to ensure patients receive timely assessment.
- End of life workstream, re-launch of 'My Care Plan' for deteriorating patients as part of a learning response.

Local improvement work

- The **purpose T** risk assessment pilot continues after being implemented in January 2025 in the North East and Central NNS teams and NRU and SRU at Kendray Hospital, evaluation of the number of assessments being undertaken has commenced for these teams. Feedback from teams participating has been positive. The second phase of the pilot is due to commence at the end of March 2025 and will include neighbourhood rehabilitation service and podiatry within the NE and central neighbourhood teams. The **Diabetes Action Group** continues to meet monthly and has various ongoing workstreams including the development of a diabetes template for SystmOne. The audit report has now been completed and has several recommendations to further improve the management of people requiring insulin on nursing caseloads. The report will be presented at the April care group clinical governance meeting.

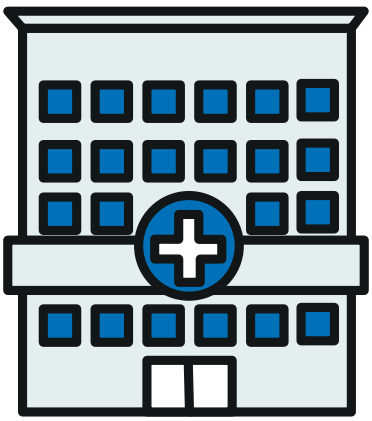
- Following partnership working with BHNFT discharge team around trial without catheter (**TWOC**), there has been a reduction in the number of patients being appropriately discharged with catheters in situ.
- An initial meeting was held in February 2025 to review the **OPAT pathway**. It was recognised that this service has developed greatly since the initial introduction in the rapid response service (now UCR). Improved relationships with the microbiologist, colleagues in the PICC line service, Diabetic Foot Clinic and SDEC which all helped in the service development. The pathway is now delivered by neighbourhood teams, which came about as national direction for the delivery of urgent community response services, our Trust completed an organisational change programme to ensure UCR had capacity to respond to patients in a crisis (2hrs). These developments have led to increased challenge within the service, leading to a need to review the pathway. A further meeting is planned for April 2025 to continue this work.

Learning responses being used

- 48 hour rapid reviews and debrief
- After action reviews
- Specialist Learning Reviews

Cheswold Park Hospital

- Cheswold Park Hospital transferred to the Trust from 1 October 2024
- They continued to use their existing risk management system Ulysses until 13 January 2025 when the transition to Datixweb was implemented
- Staff and managers received training on incident reporting on Datixweb, manager responsibilities and PSIRF from the patient safety support team
- All incident data from 1 October 2024 until 13 January 2025 was manually transferred from Ulysses to Datix to ensure complete recording
- The service commenced working under the Patient Safety Incident Response Framework from 16 December 2024
- Manual processes were established to submit patient safety incidents to NHS England via the LFPSE system until this was available through Datix reporting



Improvement work update

Inpatient falls

Through 2024-25 we have:

- ✓ We maintained falls rates per 1000 bed days under the National average, and falls related patient safety events accounted for only 4% of all Datix events reported Trust-wide
- ✓ Falls education – 78% of staff working on wards experiencing higher falls rates have received falls education, and shared staff learning and focus on falls supports ongoing education
- ✓ Cheswold Park Hospital staff have received training to use the falls risk screening, and Post falls Protocol. Their patient group is meeting NICE guidelines for falls, and will be monitored
- ✓ Safety Huddles – are taking place regularly on some wards. These wards have reported positive outcomes including improved communication, and reduced patient safety events linked with falls and violence & aggression
- ✓ Falls awareness week – working alongside the Barnsley Integrated Team, Comms Team and Patient Safety Support Team we ran several initiatives including patient education, Creative Minds session, stalls at Barnsley Market and a half day conference

Future work:

- Robust governance and review of falls related patient safety events to ensure we continue to provide high quality patient assessment and intervention to reduce falls risks. This work supports identification of any potential learning through horizon scanning review
- To ensure we are offering multifactorial assessment to optimize safe activity and mobility planning to meet the new Nationally led guidance from the Royal College of Physicians, National Audit of Inpatient Falls (NAIF) and NICE quality standards
- To review the use of post falls checks prior to a patient being moved, supporting staff with decision making in emergencies
- To review bone health screening, and developing a governance pathway
- eFalls pilot study, making sure we are relevant today and ready tomorrow

Transfer of Care

Through 2024-25 we have:

- ✓ Reviewed the transfer of care protocols which are in place between SWYFT and Barnsley Hospital NHS Trust and Calderdale and Huddersfield Hospital (separate protocols with the two hospitals)
- ✓ Gathering of learning from patient safety incidents and learning reviews which have been completed
- ✓ Liaison with colleagues at the Acute Trusts to understand their experience of following the transfer of care protocols
- ✓ Liaison with Trust colleagues from mental health inpatients, including medics and ward managers to understand their experiences of using the protocols
- ✓ Changes made to the protocols through this engagement work and incorporating the learning from patient safety incidents

Future work:

- Continue to engage with acute Trust colleagues to complete updated protocols
- Ensure this is well communicated to staff within the Trust who can utilise this protocol
- Increase knowledge of RightCare Barnsley to support the transfer of care of service users to Barnsley Hospital
- Undertake work to understand the effectiveness of the updated protocols once in place and review and amend as necessary, in collaboration with all relevant parties.

Pressure Ulcers

Through 2024-25 we have:

- ✓ Implemented a foot wound pathway, which sets out the process for podiatry undertaking first assessments for people with foot wounds
- ✓ Phase 1 PURPOSE- T roll out, which is a tool for assessing risk of pressure damage
- ✓ Trial on reducing frequency on completing wound care assessment template (release clinical time)
- ✓ Carried out process mapping of pressure ulcer documentation
- ✓ Developed new template that is ready for testing
- ✓ Moved to 48-hour manager review and stopped RCA process (release clinical time)

Future work:

- Ongoing roll out of PURPOSE- T
- Implementation of the new wound care template
- Collection of pressure ulcer data will be captured by clinical record system and flowed into community services data set, but will allow for local analysis
- Pressure ulcers will only be reported through Datix when a patient safety incident has occurred
- Pressure ulcer report
- Updating the wound care policy
- DHSC safeguarding and pressure ulcer tool to be rolled out

Healthcare Acquired Infections

Through 2024-25 we have:

- ✓ Trust's Infection Prevention and Control (IPC) annual programme outlines the IPC priorities, objectives and quality improvement actions and sits alongside the day-to-day preventative and reactive workings, inclusive of Healthcare Associated Infections (HCAIs) of the IPC service
- ✓ Give high priority to surveillance of alert organisms and other infectious organisms. Post infection review (PIR) process for alert organisms with partner healthcare organisations routinely performed by IPC team with learning reported to IPC TAG and shared with Clinical governance groups and Care group clinical governance groups
- ✓ Continue to maintain over 80% compliance with IPC and Hand hygiene training
- ✓ Above average result on PLACE

Learning responses have helped identify that…

- We need to help staff become more aware of how to treat hypoglycaemia and the escalations
- We need to routinely review NEWS2 to ensure quality of completion and clinical record keeping on all clinical observations to ensure timely documentation and include O2 saturation recording
- Staff must be proactive with hydration management and in physical health interventions to include weight management
- Where there are equipment challenges these need escalating to the appropriate department, to prevent delays and increased risk to patient safety related incidents
- There have been delays in referrals to SALT and Dietetics in some incidents, staff understanding on early referral is required
- Ensuring that information is shared on the management of infectious outbreaks and what testing is required, collecting of samples in blood or sputum have not been accurate leading to some delays in obtaining results and delays in treatment
- We need to ensure, where possible, to promote vaccination and if declined ensure this is clearly documented

Physical Health (one health approach)

Through 2024-25 we have:

- ✓ Implement training and education for staff to have deeper understanding of holistic patient care, embracing mental health / LD and physical health. The Trust has invested in clinical skill facilitators and other specialist teams e.g. speech and language, that support clinical team with physical health, providing programmes of hands-on training to services and care groups: e.g. Physical health, NEWS2, A-E assessment, GCS/head injury observations monitoring, Falls and post falls assessment, Dysphagia, Sepsis, Long term condition management, Palliative and end of life care, ReSPECT, Compression bandaging and competencies, for staff where needed.
- ✓ Implemented ReSPECT within the Trust: now embedding into practice
- ✓ Improved Tissue viability referrals and support for inpatients
- ✓ Developed head injury and A-E procedures & tools to support effective patient management
- ✓ Established a new Physical Health Operational Steering Group
- ✓ Developed a physical health in mental health and learning disabilities strategy
- ✓ A Bluelight alert around choking has been reissued, along with promotion of training. Datix incidents continue to be reviewed. Care plans have improved and referrals to Speech and Language Therapists have supported care planning

Future work:

- Embed the new Physical Health Operational Steering Group, as a collaborative forum to improve patient physical health and share practice
- Review inpatient wound care management training and formulary. This will support with effective choice of dressing, reduce antimicrobial prescribing, cost improvement and sustainability
- Review potential digital recording of clinical observations

Medication administration

Through 2024-25 we have:

- Continued to share learning/updates through Greenlight alerts
- Implemented Electronic Prescribing Medication (EPMA) and reporting starting to be shared
- Out of hours leave training package completed
- Common stock list implemented and embedded – further review to ensure effectiveness
- Discharge medicines service KPI performance above national average
- SystmOne Clozapine template implemented
- SystmOne Lithium template implemented
- Unity Centre project rolled out across wards
- AdioS system completed
- Green bag project rolled out across the Trust
- STOMP rolled out across the Trust

Future work:

Working with the nursing directorate on:

- EPMA reporting
- Addressing administration error themes

Serious Incident concluded in 2024/25

There were four serious incident investigations concluded, these involved:

- A 52-year-old gentleman who accessed older people's intensive care services and in-patient services who sadly died of physical health concerns following a diagnosis of early onset dementia and contracting Covid-19.
- A 65-year-old gentleman who also accessed older people's intensive care services and in-patient services who sadly died whilst being absent without leave from the ward, full details of circumstances of death are not known to the Trust.
- A 74-year-old gentleman who accessed older people's outreach services and in-patient services and also had an admission to a working aged adult ward who sadly died from asphyxiation following placing a plastic bag over his head.
- A 41-year-old gentleman who accessed early intervention services, core services and

enhanced mental health services who was found hanging in a public area by passers-by and sadly died from his injuries in hospital.

The Serious incident investigations involved 9 different services and 20 team members – they were all given an opportunity to reflect on the person known to them and the care they received as well as an understanding on the areas of challenge or difficulties faced by individuals and the teams.

We learned that…

- NEWS2 scores were not always recorded as per policy.
- Care planning was not always documented as it should be.
- Clinical recording was not always as detailed as it could be.
- Risk assessments were not always completed as they should be.
- Carrier bags were being treated as prohibited items, which required risk assessment for service users to keep, rather than banned items on some in-patient areas.
- Contact with family/carers may not always be taking place when informing safety planning and carers' assessments were not always considered.
- Communication within and across teams occasionally lacked detail in relation to service user risk and safety planning
- There was limited joint working between the Trust and partner organisations.

We found…

- Audit completed by Resuscitation Lead found that daily charts were completed correctly.
- Improvement workstreams were already in place in respect of families/carers and their involvement and support.
- Improvement workstreams were already in place in respect of care planning, risk assessment and record keeping.
- Improvement work had already been undertaken in relation to the use of plastic bags within in-patient areas.

Family Liaison Officer

Yvonne Robinson, Family Liaison Officer started work with patient safety in August 2023.

Through 2024-25 we have:

- ✓ Attendance at care group PSOG meetings on a regular basis.
- ✓ Established links with the trauma informed pathway.
- ✓ Links with country-wide FLOs further established with the aim of attending a UK-wide, face to face networking/learning event in Autumn 2025
- ✓ Established regular meetings with customer services and colleagues in the Trust's legal department.
- ✓ Bereavement link supporter role has been finalised and will be launched during dying matters week in May 2025.
- ✓ FLO feedback questionnaire has been devised in collaboration with patient safety partners – aim for this to be rolled out in May 2025.

Search of Engaging and involving patients and families on the Intranet

Future work:

- Further development of the Trust's Bereavement Standard, including development of the intranet and internet pages.
- Education sessions to take place in Autumn 2025 for bereavement link supporters.
- Task and Finish group regarding involving families and carers in learning following an incident.

Some recent comments:

"Just want to say thank you for all your support this past 9 months, you have been amazing, thank you so much."

"Yvonne, thank you for helping us in every aspect possible in our grief and loss."

Learning Library 2024/25

- Number of Bluelight alerts to share urgent learning
- Homelessness
- Staff purchased medical devices
- Children's Safeguarding Review Panel Annual Report overview
- Child safeguarding practice review annual report overview
- Safeguarding preschool children with parents with mental health needs
- Safeguarding advice line
- Information sharing guidance for safeguarding
- Focus on falls – confusion and falls issues
- Understanding the long-term impact of domestic abuse
- Learning from external safeguarding adults review
- Recording a Datix for an Incident of Violence and Aggression
- Non-contact sexual offences
- Political stickers
- Self neglect section 42 case
- Translation and interpretation
- Joint agency response and child death review meeting
- Elective home education
- Domestic abuse nursing silent epidemic
- Urinary retention
- Systems analysis of inpatient fall involving a medical device
- Child and adolescent to parent violence and abuse
- Death of a community mental health patient following importing medications from USA

- Lethal means and online access update
- Transition of care between CAMHS and primary care services
- Voice of the child
- Migrant victims of domestic abuse
- Domestic abuse, stalking and harassment and honour-based abuse risk assessment

Search for Learning library on the Intranet

23 April 2024

- Family liaison officer role
- Learning from Forensic care group
- Evaluating staff use of the Trust frailty screening tool and their management of frailty
- Care review report

24 July 2024

- Reducing health inequalities review – learning from lives and deaths (LeDeR)
- Falls case study using systems analysis tools

11 September 2024

Focus on falls and patient safety to celebrate World Patient Safety Day

- PSIRF overview
- Patient Safety Partner role
- Creative Minds – falls reduction work
- Learning Disability and falls prevention
- Falls improvement work

Learning from healthcare deaths

An overview of themes identified from reviews and investigations that have been completed during 2024/25 will be included in the next learning journey.

Next steps for 2025/26 include a review and refresh of the mortality review group to provide opportunity to refocus how we learn from deaths and identify problems in care.

Thank you for supporting a patient safety culture

Contact the patient safety team: patientsafety@swyt.nhs.uk