South West Yorkshire Partnership Teaching NHS Foundation Trust

# Our Learning Journey

## Quarter 2 2025/26

**Patient Safety Support Team**

**October 2025**

With all of us in mind.

# Patient Safety Incident Response Framework

A review of our PSIRF plan, policy and working procedures is currently underway. We are taking the time to reflect on our experiences and feedback to ensure this is enhanced going forward. The review is being approached under four main workstreams aligned with the aims of PSIRF. Workstreams and updates on work underway or planned is shown below:

## 1) Compassionate engagement and involvement of those affected by patient safety incidents

- Revisiting our Being Open guidance (known as engagement and involvement under PSIRF)
- Flowcharts and letter templates have been developed to assist staff in the practical steps to take with the Being Open process. This includes when there is/isn't a learning response underway. It also considers where there may be family questions raised directly with a team or through customer services and how we will respond with a considered and streamlined approach. These are now being piloted.
- Feedback from staff and patients/families is being requested after involvement in a learning response to ensure we use the feedback to improve our systems and processes.

## 2) Application of a range of system-based approaches to learning from patient safety incidents

- Redefining our learning responses tools (for example, we are considering renaming a team debrief to align with the national terminology)
- Revising guidance for each learning response tool including templates
- Defining who will lead each type of learning response
- Reviewing timescales for completion
- Reviewing support materials

## 3) Considered and proportionate responses to patient safety incidents and safety issues

- Introduced a PSIRF learning response decision meeting where we discuss and agree on the most appropriate response type (where relevant).

- A PSIRF response decision flowchart has been developed to support consistency in this decision making and giving care groups information they can consider before attending the group.
- An Incident review flowchart has also been developed to complement the above. It aims to give ward/team managers a visual tool of the steps involved in reviewing incidents, and when other processes may be required.
- The next phase of work will explore how we can improve how we capture improvement activity and extracting outcomes from Datix.

### 4) Supportive oversight focused on strengthening response system functioning and improvement

- We are continuing to refine the existing oversight processes in light of PSIRF – this consists of the Patient Safety Oversight Group and Patient Safety Improvement Group.
- During August 2025, we commenced a Patient Safety Executive Group that will work alongside these two groups. This is a small group of patient safety specialists and executive directors with responsibility for patient safety, where oversight of high-level learning responses can be maintained through regular discussion. This is an evolving group which will develop over time.
- The terms of reference for all three meetings are under consultation to ensure each forum has a clear focus.

## Case Note Review

An older adult patient with significant pre-existing medical conditions was under the care of Barnsley neighbourhood nursing service. The service user had been receiving cancer treatment in hospital (end of life) and had returned home with a category 2 pressure ulcer, which deteriorated to a category 3 (he declined pressure relieving equipment). Whilst he was in hospital, he had been experiencing symptoms of breathlessness and pain. He had been having domiciliary carers, visiting once daily (as the family found the frequency of more visits intrusive).

The review found:

- The patient was on caseload for support visits, but these could have been more frequent given his palliative condition.
- Holistic assessments could have been improved, as there was minimal documentation.

Safety actions taken were :

- Feedback was provided to the team at weekly huddles.
- Training around symptom management was organised.
- Promotion of echo training.

Existing quality improvements already under development, were:

- Pain management leaflet for patients and families
- Best practice guidance for district nursing
- My Care Plan underway- looking at digital solutions and clear guidance/care plans around supportive, deteriorating and last days of life.

A young person had been found collapsed at home by a family member. Ambulance was called and the young person was pronounced deceased on arrival at hospital. The young person had been discharged from CAMHS the previous month. The young person had relocated to the area within the last few years and had been experiencing bullying at school (leading to non-attendance), gender identity issues and queries about autistic traits/ASD.

The review found evidence of good practice: -

- Good consistent record keeping and contact with the young person and family.
- Multi-agency liaison with school and support from wider agencies e.g. gender identity services.
- Care plan was young person centred with voice and goals throughout care.

Learning identified: -

Discharge arrangements were unclear;-

- There was no reference to the young persons voice surrounding their thoughts and feelings about discharge from the crisis team.
- There was little reference to information sharing with other agencies on discharge from the crisis team or when discharging from CAMHS.
- The tone and wording of discharge letters sent to the young person and family were very formal and lacking compassion and did not promote engagement and utilisation of appropriate safety planning and accessing help when needed.
- The quality of the discharge did not capture the historical indicated risks.

Areas for improvement were added to the Children and Young Person Service Quality Improvement Plan.

A young person had reportedly died after falling from a height whilst on holiday. The young person had been known to child and adolescent mental health services (CAMHS) services for many years and more recently leading up to the incident had contact with single point of access (SPA) within adult mental health services. The young person had a diagnosis of ADHD and ASD. During SPA assessments they stated they had stopped taking their medication and felt 'ok', and there was no clinical need for ongoing support from secondary mental health services and was discharged to their GP.

The review found learning identified:

- **Transition and discharge planning** – reminder to both child and adult services of joint responsibility to review clinical record as part of triage and assessment process. The transition process and flowchart has been reviewed and confirmed by both CAMHS and adult mental services.
- **Voice of the young person** – all reasonable efforts must be made to gain the young persons wishes directly and rationale clearly documented in the clinical record where contact is through parents/carers. Feedback surrounding best practice and good examples have been shared with the CAMH service.
    - **Consent to care, treatment and discharge tool** – CAMHS clinicians have been reminded of the expectation to use this tool at the point of entry, beginning of any intervention, at significant change in intervention and at the point of discharge. Ongoing monitoring will be offered through line management and caseload supervision. E-learning is now available via ESR on the intranet
- **Clinical risk assessment** to be captured accurately within the clinical record.
- **Medication** - Best practice guidance of 6 monthly reviews should be followed in relation to reviewing efficacy and dose.
- **Discharge** letters must be copied to the GP.
- An **increased risk of suicide** in those diagnosed with ADHD and autism – clinicians are encouraged to be professionally curious when exploring risk and collaborative care planning.

## Enhanced Case Note Review

A patient safety learning response was conducted in the form of an Enhanced case note review following the unexpected apparent suicide of a lady on leave from an older people's mental health inpatient ward.

We learned that ….

- The Patient Safety incident responses relating to inpatient apparent suicides need to ensure full engagement with the relevant teams at the earliest opportunity and that support systems for staff are clearly shared with the teams at the first point of contact.
- Community older people's crisis service need to ensure that additional information sourced via longer periods of contact with a patient are captured within the comprehensive assessment tool at key points of transfer or changes in care pathways.
- The ward teams need to ensure that succession planning for extended roles and responsibilities such as carer's lead and other such champion roles are embedded within team development and individual or group supervision discussions.
- Across the community and the inpatient wards, the information available for families on recognising the risk to suicide was not known about and had not been shared. The booklet was not in printed format and relied on staff awareness and ability to access this on Trust intranet and internet pages.
- Staff supervision process on the ward would benefit from including discussions on suicide risk and management of risk, the formulating of the understanding of the person's risk to suicide and the knowledge and awareness of appendix 4 of the all patient leave policy and what to document in systmOne.
- The ward environment, heating, doors, and the planned priority programme of works along with the need to ensure that the findings from the review are fed through to the clinical environmental safety group and that the findings on the environment regarding noise, comfort, lighting and patient factors impacting on decisions to stay, are shared into the Trust wide 'culture of care programme.
- All staff across community and inpatients, when communicating clear information (in high pressured situations) need to familiarise themselves with the SBAR tool as a communication aid and how this can support communication in high risk situations.

## Patient Safety Incident Investigation (PSII)

A patient safety incident investigation was carried out following the death of a gentleman who was found to have hung himself at home. The man was under the care of the Intensive Home-Based Treatment team at the time of his death. He had had recent admissions to Stanley ward as well as an out of area placement.

The PSII was completed by a lead investigator with input from staff involved in his care, patient flow and the service user's family.

We learnt that:

- There is a need to increase access to **psychological therapies input** to IHBTT in Barnsley to support psychological formulation and the teams wellbeing following traumatic incidents.

- Work is underway in the Trust to review and **implement new national guidance** 'Staying safe from suicide: Best practice guidance for safety assessment, formulation and management' to support staff and service users.
- The IHBTT team had a **robust system** for the paper and electronic **recording of case management review meetings** with the investigation highlighting the need to ensure this is replicated across other teams.
- The investigation highlighted **strong inter-team working** to ensure a patient centred approach to caring for someone who was affiliated with the Trust. This helped to maintain confidentiality, however this was managed informally. The Trust will now look to establish a **clear pathway** for staff or individuals affiliated with the Trust when accessing Trust services.

A patient safety incident investigation was completed following the death of a young woman who had been an inpatient on a mental health acute admission ward for 6 months.
The investigation included a systems analysis and mapped areas of care pathway, care management and care plans. The family remained actively engaged in the process from the outset and wished to include a number of areas for consideration in the investigation process.

We learned that ….

- Complexity of care needs for Autism, self-harm and suicide risk pose significant challenges for inpatient mental health services and staff managing the holistic needs of the person.
- There is a need for increased training in complex case needs and Autism.
- There is no adult pathway for Avoidant Restrictive Food Intake Disorder.
- There was a limited availability of accommodation/Placement able to support the patient's complexity of need.
- There is a need to ensure that lived experience of Autism is utilised to ensure that the personalised care planning process is supportive and reflective of the neurodiverse needs of individuals and that this works connects to the Culture of Care Programme.
- There is learning to take forward in the management of external wounds on inpatient mental health wards.
- There are multiple operational policies at influence when considering the escort of patients to the emergency department, the learning from this investigation will be fed through into the Trust wide work for Enhanced Therapeutic Observations in Care (ETOC).
- Challenges remain across inpatient mental health surrounding the access to means for harm, a blade was accessed via mail order by being taped inside a magazine, staff alertness to the creative ways of accessing means will be reviewed through the Trust wide suicide prevention work.

- Planning for service user support at the point of handover needs to be undertaken within the meeting, supported by written, verbal and electronic information to ensure decision making is proportionate, safe and supportive to service users and staff.

# Improvement work and care group updates

We are continuously trying to develop the ways in which we share learning and feedback from our improvement work.

Moving forward improvement leads and care group representatives will populate an update slide to share at the Patient Safety Improvement Group (PSIG) or provide a verbal update. Some examples are shared below.

These updates will then be shared within our quarterly patient safety oversight report and this learning journey moving forward.

# Improvement work update

## Suicide prevention/self-harm

### Current improvement work and updates

- Inpatient Self-harm external wound management being actioned through the physical health improvement group
- PSSI for inpatient suicides, thematic analysis has been on hold due to time and capacity pressures
- Suicide Prevention Strategy update in progress
- Training for NHS England safety from suicide has been released, support is being provided by Learning and Development for access through ESR
- Apparent suicide report for 24/25 in progress

### Completed improvement work

- Programmes of work are ongoing.

### Upcoming /new improvement work

The Trust is increasing connections to regional near real time suicide surveillance learning panel.

### External / national reports /guidance (including HSSIB)

- https://www.hssib.org.uk/patient-safety-investigations/mental-health-inpatient-settings/interim-report/

The above link cements the understanding on the need to move away from risk stratification in understanding suicidal crises. This works is connected to the personalised care planning and risk management improvement as well as supporting of the organisations aims for suicide prevention. The report findings highlights the importance of biopsychosocial assessments and safety planning in mental health inpatient units and supports our organisational actions already underway for collaboratively care planning and narrating of individual risks.

## Transfer of care protocols

### In the Trust's PSIRF plan, we intended to gather intelligence through 2024 and 2025 to inform improvement work.

### Current improvement work and updates

- Review of transfer of care protocol with BHNFT, this now includes and memorandum of understanding
- Development of a new transfer of care protocol with MYTT. A meeting is scheduled for later in October to review the draft version.
- Protocols incorporate learning from incidents involving transfer of care between SWYPFT and acute Trusts.
- A flowchart has been developed which summarises the protocol for patient facing staff.

## Medication Administration Errors

### Current improvement work and updates

- EPMA now live in all IHBTT, 136 suites in Wakefield and Barnsley and Calderdale go live end October 2025

- Missed dose report available from EPMA and reviewed at safe medicines practice group.
- Greenlight alerts produced relating to risks around multi-dose compliance aids and “potting up”
- Valproate safety guidelines updated in response to clinician enquiries relating to women who do not accept the pregnancy prevention programme.

# Physical Health

## Current improvement work and updates

- To further support the commitment to improving physical health within our services the Trust has a physical health operational steering group. This group provides support and will be a central repository for Physical health initiatives. There is multi-disciplinary membership, with shared interest and motivation and from all care groups and services, including specialist services
- Training and awareness around physical health related conditions is being offered, e.g. vital signs / NEWS2, diabetes, falls, wound management, hydration, sepsis, long term condition management, Palliative care / end of life, ReSPECT training, Epilepsy, using multi methods of delivery – eLearning, clinical skill facilitators, workshops
- Provide eligible vaccination to service users e.g. Flu vaccination, COVID, RSV
- Management of Diabetes Mellitus in adult inpatients- SOP
- Mental health inpatient wound management
- The Trust are exploring e-observations for clinical services. A digital solution to record the vital signs, NEWS etc of a patient.

## Completed Improvement Work

- NEWS2 implementation inpatient and Barnsley PHW community
- Visual A-E Assessment SOP - A-E assessment tool has been developed, approved and is being used
- Head banging/ head injury procedure approved.

## Upcoming/New Improvement Work

- Proposal for purpose T to be introduce for inpatient wards (already implemented in Barnsley PHW)
- Explore processes and education for pain assessment and management for inpatients.

# Healthcare Acquired Infections

## Current improvement work and updates

- Annual plan is in place which includes AMR – All actions are to timescale
- Annual quality assurance improvement schedule is in place
- Quarter 1 quality improvement work has highlighted:
    - Improvements with outbreak management, risk assessment tools for outbreak management, infectious isolation standard principles, SystmOne IPC templates, urinary catheterization and sampling procedures and training
- All IPC Datix incidents are reviewed by the IPCT team specialist advisors, any actions and learning is escalated and included in improvement plan
- Continue to monitor cases of alert organisms / conditions, mandatorily reportable infections/conditions and areas of increased prevalence to inform the Trust on preventative measures and support patient safety
- Utilise every opportunity to increase knowledge and awareness of IPC and monitor mandatory training compliance

## Completed Improvement Work

- Monitoring of the IPC service provision takes place through IPC Trust action group (TAG) and service management
- A thematic review of HCAI's from 2024/25 was undertaken and learning shared to respective governance groups to support practice
- All standard operating procedures have been reviewed and are up to date

## Upcoming/New Improvement Work

- Quarter 2 work plan is being reviewed for future improvement work
- Antimicrobial prescribing audit is due October 2025
- PLACE audit are taking place for inpatients

# Falls and Bone Health

## Current improvement work and updates

- NICE (ng249), falls: assessment and prevention in older people and in people aged 50 and over at high risk of falls. The new guideline is under review, supporting any updates required in the Trust falls and bone health policy and inpatient falls management template
- a bone health report has been presented at the Trust wide Physical Health Optimisation meeting, with further work agreed
- NICE quality standard for falls in older adults aged above 65yrs. This work continues and a 25% increase observed in patient education documented within progress notes and mobility plans
- eFalls work is in the process of being written up, and sent for validation

### Completed improvement work

- falls awareness week was successful, with several wards including Cheswold Park having falls awareness events, quizzes, escape room, and patient/family education. The Comms Team have been integral in the presentation of the work in the Trust Headlines and on social media channels
- observation levels and falls – report and action points presented at the Trust wide temporary staffing meeting

### Upcoming /new improvement work

- essential to job role regarding falls awareness training is under review. Potential work includes a restructure of the current training package

# Violence against patients

## Current improvement work and updates

- Safewards package has been developed and pilot wards identified.
- Cheswold Park Hospital instructors supported to upskill in order to deliver RRPI package at Cheswold, RRPI staff have been allocated to co-facilitate.
- Support Trust ambition Prone reduction.

## Completed improvement work

- Safety pod audit completed and now being analysed.

## Upcoming /new improvement work

- Quality improvement work identified around seclusion aimed at improving staff practice and decision-making and the service-user experience.
- Outreach work to inpatient wards to offer support and guidance over themes identified in RRPI TAG and other forums.

# Pressure ulcer deterioration

The **PSII** clinical documentation related to pressure ulcer care has been completed and ongoing improvement work continues to address areas for improvement identified. The work was presented at the Patient Safety Improvement Group in October 2025.

Purpose T has been implemented in Barnsley Physical health and wellbeing services.

Barnsley physical health and wellbeing care group noted issues relating to access to interpreters with community services in quarter 1 and monitoring of incidents continues and working with the Trust Equality and Involvement manager to resolve any issues.

# AWOL from inpatient wards

In the Trust's PSIRF plan, we intended to gather intelligence through 2024 and 2025 to inform improvement work. Incidents are reviewed through the Clinical Environment Safety Group.

## Current improvement work and updates

- MISPER policy is in final stages of completion due to be signed off and live from November 2025

## Upcoming /new improvement work

- Improvement work to be commenced with police and YAS leads from localities to learn from incidents.
- Review of courtyards to be undertaken to consider further work to help reduce the number of AWOL incidents

# Cheswold Park

## During Q2 2025/26 we have:

- We have restarted the Physical Health Forum which includes oversight of the Physical Health Action Plan.
- We have restarted a fortnightly Clinical Security Forum to have oversight of an increase in Clinical Security incidents.
- The Water Quality work continues across the hospital with support from estates and facilities and IPC.
- We have implemented Trust approved Red Bags and equipment across all seven wards.
- Reducing Restrictive Physical Intervention (RRPI) training rolled out from 29th September 2025.
- EPMA project group commenced - September 2025.
- We had a Learning event held in August 2025, following the death of an inpatient due to natural causes.
- Two members of staff have commenced the Professional Nurse Advocate course.

## Future work:

- E-Seclusion live from 1st October 2025.
- Review of Clinical Security across the hospital and bringing this in line with the wider Trust standards.

- EPMA roll out to commence in January 2026.
- Co-delivering a wider forensics learning lessons event in November 2025.
- Medicines with respect training and competency assessment starting in October 2025.
- CPH local PSOG to integrate with the wider forensic PSOG (08/10/2025).

## Forensic Care Group Q2 West Yorkshire

### Current improvement work and updates

- Observation & engagement package delivered on 3 occasions – need a plan to roll out.
- Dysphasia training
- Informal patient located within a secure unit
- Recall to hospital and RCRP

### Completed improvement work

- Victims guidance document
- 1 minute guide developed when member of staff left visitors unattended
- Observation and engagement training package

### Upcoming /new improvement work

- News2
- Escorting patients off site in challenging situations
- AWOL and cross police force working

## Family Liaison Officer (FLO)

- Launch of bereavement link supporter role has taken place with information shared with all staff across the Trust via payroll.
- The first meeting with those recruited to date took place on 20th October with more meetings and action planned.

- The FLO role continues to grow with positive response from families who have received the contact and the support offer from the Trust.
- Links have been strengthened over the last two years with partner organisations regarding supporting the bereaved.
- A survey is planned to help shape the future of the role regarding contact and support to families.
- The FLO continues to lead on the development of a bereavement standard for the Trust with the help of the bereavement link worker roles.

## Learning Library Q2 2025/26

Number of **Bluelight alerts** to share urgent learning

Bluelight alert 104 - 29 July 2025 - Snap frame potential weapon and self-harm risk

Bluelight alert 103 - 24 July 2025 - Ligature risk from door lock latch

Bluelight alert 102 - 9 July 2025 - UK emergency alert test

Learning Library

SBAR Reporting service users to DVLA.docx
SBAR - Animals in Service users homes.docx
SBAR safer sharps safety device.docx
SBAR safeguarding advice line.docx
SBAR - Risks relating to external facing windows.docx
SBAR - EPMA and admission from IHBTT virtual ward to inpatient ward.docx
SBAR - Accessing Electronic Patient Records August 2025 final
SBAR Sharps management safety closures 2025.docx
SBAR - vape incident 2025.docx
SBAR Medication administration (insulin) and clinical record keeping.docx
SBAR- Medical Devices and therapy equipment - March 2025 V4.docx

# Thank you for supporting a patient safety culture