South West Yorkshire Partnership NHS Foundation Trust

Our Learning Journey

Quarter 1 2025/26

Patient Safety Support Team

August 2025

With all of us in mind.

Patient Safety Incident Response Framework

18 months into our PSIRF journey, we are now reviewing our PSIRF plan, policy and working procedures based on our experiences and feedback.

The review is being approached under four main workstreams aligned with the aims of PSIRF. Workstreams and updates on work underway or planned is show 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).
- This includes the development of a flowchart to assist staff in the practical steps to take following a patient safety incident including 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 streamlined approach.
- Introduction of seeking feedback from staff following involvement in a learning response and from bereaved families through our family liaison officer. Feedback received is being used to improve on 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.
- Revising processes to help us understand what is known already to help us make a robust decision.
- Defining who will lead each type of learning response.

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

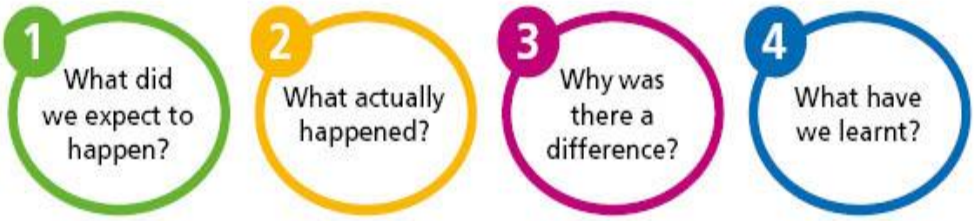
- Developing a new decision-making process to support staff with understanding when a learning response or improvement activity may be required. This includes a learning response decision making flowchart to support in choosing the most appropriate response.
- Improving DATIX for capturing improvement activity and extracting outcomes.

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 are trialling 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 in development to ensure each forum has a clear focus.

Search for PSIRF on the intranet

Learning Response outputs



After Action Review 1

An After Action Review was completed with representation from the Single Point of Access (SPA) service. The Intensive Home-Based Treatment Team (IHBTT) service and the Mental Health Liaison team (MHLT) service from Calderdale and Kirklees area following the death of a gentleman who fell.

The After Action Review involved face to face meeting with staff impacted by the incident guided by lead patient safety specialist and had representation online.

We learned that ….

- It was identified that there is no guidance for staff in relation to contact and assessments of service users who are under the influence of alcohol, it is down to the professional's judgement.
- Consideration and review to be given to how services and practitioners can support the safe discharge of a service user, deemed to have capacity, where family or carers express concern in relation to risk management and/or are not in agreement with assessment outcome.
- Quality and Governance lead to develop and implement a guidance document for IHBTT and MHLT assessing service users presenting under the influence of alcohol or drugs in a mental health crisis for consistent and safe assessment and intervention.
- The guidance will include the need to communicate any plans of assessment and care with family and carers where applicable and reaffirm documentation standards to support clear decision making and formulation.

After Action Review 2

An After Action Review was completed with representation from the Calderdale Child and Adolescent Mental Health Service (CAMHS) crisis team and external agencies following a death of young person.

The After Action Review involved face to face meeting with staff impacted by the incident guided by lead patient safety specialist.

We learned that ….

- Discussion with the young person to confirm their views prior to discharge is important and that managing differing expectations between service users and their family can be challenging.
- Upon discharge young person should have been signposted to services as part of discharge plans.
- Documentation in relation to referral, discharge and communication with partner agencies requires strengthening.

After Action Review 3

An After Action Review (AAR) was completed with representation from multi-disciplinary staff on

Beamshaw Ward at Kendray Hospital Barnsley, including support from occupational therapy. This was following the discovery of an inpatient having a seizure within the grounds of the hospital, whilst on ground leave, who had also sustained a head injury.

The After Action Review involved a face to face meeting with staff impacted by the incident guided by a lead patient safety specialist and had representation online. Staff had also completed memory capture documents prior to the AAR.

We learned that ….

- There was a delayed response from staff on Beamshaw Ward as there is no protocol for using alarms outside of the fabric of the building. There is a panic alarm button behind reception which could have been used. The panic alarm button has been tested and reception teams have been reminded of using it in urgent situations.
- There is no protocol or equipment available for moving and handling outside of the building. This area for improvement has been shared with the Trust's moving and handling specialist advisors for their consideration.
- Staff are parking in designated no parking areas for easy access to their work area. A Trust-wide communication has been circulated to remind staff of the importance of not parking vehicles in designated areas where emergency services access may be required.
- Support has been offered to peers and staff who witnessed the incident vis Occupational health and psychology. The service user is very grateful to all staff involved for their care and support at the time of the seizure.

After Action Review 4

An After Action Review (AAR) was completed with representation from multi-disciplinary staff at Cheswold Park Hospital, Doncaster. The incident involved a delay in receiving and reviewing a patient's assay clozapine serum level over a period of 14 days, which then delayed treatment being ordered and administered to the patient.

We learned that ….

- As a result of this, an on-call tray has been placed in the medical secretaries' office for all results for patients whose associate specialist is absent on that day, so that these can reviewed by the on-call doctor and once read will be entered on SystmOne. The medical secretaries will email all doctors to inform them that post is present in the on-call tray. There is an on-going liaison with external laboratory to discuss process for receiving results with possible change from post to email.

Assessment Response outputs

Structured Judgement Review 1

A service user under the care of core team in Barnsley died by apparent suicide using prescribed medication. A structured judgement review was carried out by a clinician independent of the service. The service user had a diagnosis of bi-polar affective disorder. They had been under the care of the team for around 18 months prior to death. They had regular appointments with the practitioner and support worker. They had a number of physical health diagnoses. The service user was reviewed with the practitioner and support work and agreed to discontinue work. They had ceased working due to poor physical health. Their care transferred to the team psychiatrist to be seen as an outpatient.

The review identified:

- The service user had previously reported looking up her medication and didn't feel they would be beneficial. This was the medication used to take her own life.
- Risk assessment documentation could have been improved however there was evidence within the care records that her mental wellbeing was assessed on each visit.
- Care was recorded to be Excellent.

The quality of the records were recorded to be excellent.

Structured Judgement Review 2

A service user under the care of Intensive Home-Based Treatment Team (IHBTT) in Barnsley died unexpectedly, cause unknown. The service user had been receiving care from IHBTT following GP reporting suicidal ideation. He was assessed by Single Point of Access Team and IHBTT. He had regular contact with the team. There was no current evidence of suicidal thoughts. The team endeavoured to engage via phone and cold calls. Service user was due to go on a trip. Due to concerns for welfare raised, police were contacted for a welfare check. The service user was found deceased on entry to the home.

The review found:

- The service user did not always engage with services, however the records evidence the team were persistent in their efforts to engage and when unable to contact by phone, would cold call at his home with success.
- The team's good working relationship with the service user was noted. He was honest about drug and alcohol use.
- When he expressed doubts about his diagnosis and the need to take medication, a face-to-face Consultant appointment was arranged at his request to discuss his concerns.
- It is evidenced in the notes that staff allowed Mr X time to discuss his thoughts and fears and were able to reassure him, and also provide education regarding his symptoms and plan of care.

Mr X held firm views which were thought have a delusional element to them by the staff caring for him. They contacted members of Mr X's family with his permission to gain background information about these beliefs which is good practice.

The conclusion was that there was some basis to Mr X's delusional thoughts.
Care was recorded to be excellent overall.
The quality of the patient record in enabling good quality care was assessed as being good

Structured Judgement Review 3

A service user under the care of Enhanced team East Wakefield died at home due to a deterioration in their health. This was later reported to have been from pneumonia. They were 29 years of age and died at home.

The service user had a history of homelessness, drug use and periods of non-engagement. There was a diagnosis of schizo affective disorder. There was a history of hospital admission and early intervention team. In the months leading up to death, there was some deterioration in mental state, ongoing drug and alcohol use, alongside difficulties engaging with staff and becoming homeless. Family reported sporadic engagement prior to death.

The review found:

- The service user received a good standard of care.
- The quality of care from the team to the service user was needs led and with compassion and understanding, they appeared at times to work above and beyond, particularly in relation to his relationship with his family.
- Record keeping was at times inconsistent or unclear but was reviewed.
- Work was attempted on numerous occasions with little impact due to the situation the service user often put himself in.
- Good robust assessments when he attended A&E and even when in other areas, good communication evident between teams to share relevant information.
- Care was recorded to be good overall.
- The quality of the patient record in enabling good quality care to be provided was assessed as being adequate.

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.

- One PSII has been commissioned this quarter having been escalated from findings from a case note review.
- There are a small number of other PSIIs that remain underway.
- There is an additional PSII going through the governance stage.
- There is a proposal for a new PSII review and sign off process at director level which is under review at the newly appointed patient safety executive group.

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

Falls and bone health

During Q1 2025/26 we have:

- continued to review all falls related safety events for themes and learning
- NICE quality standard for falls reviews are supporting the implementation of physiotherapy screening and assessment tools. It is also auditing the quality of mobility plans for patients 65yrs and above
- falls awareness week takes place week commencing 15th September 2025, with lots of activities planned so far; fully supported by Barnsley integrated team, inpatient wards, Creative Minds and the Comms Team
- highlighted that the Welsh health board Betsy Cadwaladre was fined by the Health and Safety Executive, and a report offering assurance and potential recommendations developed
- SBAR developed around medical devices and therapy equipment

Future work:

- NICE guideline (NG249) - 'Falls: assessment and prevention in older people and in people 50 and over at higher risk' was published 29 April 2025. This new guideline will be reviewed to support the update of Trust-wide falls and bone health policy and the inpatient falls pathway
- eFalls work continues alongside the research and development team
- bone health work is ongoing with a report being planned for the physical health operational steering group
- a review is underway regarding the use of observations for falls risk

Children, Young People and Families Care Group

- An audit completed in Child and Adolescent Mental Health Services (CAMHS) identified a pattern that learning from previous patient safety incidents was not being embedded across teams. As part of this piece of local oversight work, 5 common themes were identified to develop a CAMHS patient safety improvement plan.

- Some of the improvements to come from this were the development of an e-learning package around consent to share, improvement work around engagement and communication of crisis plans, ensuring they are shared with the young person rather than the family member.

- The above is an example of a local piece of oversight work which aims to demonstrate sustained improvements within CAMHS.

Cheswold Park Hospital

Local improvement work

- **Medication Management Quality Improvement Work** – Involvement from the Trust Quality Team to understand the need for improvement at CPH and we are now at the stage of observing medication rounds to gain vital data. EPMA is on hold until March 2026.

- **Observation and Engagement Quality Improvement Work** – Involvement with the wider forensic care group to deliver training around changes within Observation and Engagement and support to implement the Trust policy into CPH.

- **Infection Prevention and Control Action Plans** – These are in place for each ward at CPH and IPC Team have oversight.

- **Plastic Bag Audits** – Implementation of an audit to review and reduce plastic bags within all inpatient wards at CPH.

- **Physical Health Forum** – This has been set up to improve patient's access to Physical Health interventions and monitoring at CPH.

- **Training** – Upskilling CPH staff in relation to clinical skills, such as, venepuncture, clinical record keeping and post-falls awareness training.

Family Liaison Officer

- Launch of bereavement link supporter role has taken place.
- Interest in the role expressed by approximately 20 colleagues so far (1:1 meetings have taken place to further discuss the role).
- Full day information session for bereavement link supporters arranged for 20/10/25 with guest speakers attending.
- Involvement in discussions regarding development of a FLO training programme – a working group has been established with the first meeting taking place on 27/08/25.

Learning Library Q1 2025/26

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

- UK emergency alert test
- Risk associated with carpet threshold strips
- Learning from fire incident
- Use of batteries in service user areas

Learning library -

WEB186917 Room out of use due to water quality issue
Threats to staff secure CAMHS
Focus on Falls - Urinary incontinence and falls issue
Cheswold Park Hospital - Courtyard Garden SBAR
Cheswold Park Hospital - Learning from incidents involving patients who require A & E intervention but decline to attend
WEB187601 Cheswold Park Hospital - Near miss choking incident

Learning from healthcare deaths

During Quarter 1, a review of the Mortality review group took place as part of the review of our Patient Safety Incident Response Plan. It was identified that the majority of the meeting's content focussed on processes rather than learning themes from our own deaths. As such it was felt that themes emerging from deaths we have reviewed was more appropriate to link with the re-launched Patient Safety Improvement Group. A refreshed agenda which includes learning from deaths will commence from September 2025.

Thank you for supporting a patient safety culture