Quality Report
2013/2014 and
Forward Strategy
2014/2015
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## Quality report 2013/14 and forward strategy 2014/15

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I am delighted to welcome you to the Rotherham Doncaster and South Humber NHS Foundation Trust Quality Report for 2013/14, which focusses on how the Trust is working to meet our quality ambitions and reflects on our achievements and areas for improvement.

We aim to deliver our vision of ‘Leading the Way with Care’ by ‘promoting health and quality of life for the people and communities we serve’ and through the implementation of our five strategic objectives:

- Continuously improve service quality (safety, effectiveness and patient experience) for our service users and carers
- Nurture the talent, commitment and ideas of our staff in order to deliver excellent services
- Ensure value for money and increased organisational efficiency whilst maintaining quality
- Adapt and deliver services to meet agreed commissioned needs through enhanced multi-agency partnerships
- Maintain excellent performance and governance and a strong market position; and improve further our reputation for quality

The economic circumstances in the public sector continue to have an impact and the market for healthcare is increasingly becoming more competitive. We can no longer assume that NHS provided care is the first or most optimal solution for commissioners to meet the needs of their populations. We must be able to compete and demonstrate that we can operate efficiently, to high standards of customer care and in line with commissioner expectations. The way in which we position ourselves by ensuring we keep ahead of our competitors in terms of quality and service user/patient feedback, working flexibly and imaginatively with what we know are reducing resources and delivering care in a way that is innovative and developmental will stand us in good stead for the future and must be beneficial for our patients/service users.

To be able to meet these challenges we have continued to deliver our programme of quality improvement work, focussing on the three Trust quality priorities:

- Personalised care
- Record keeping
- Clinical leadership

In September 2013, the Trust held its Annual Members’ Meeting and Awards Ceremony at the New York Stadium in Rotherham. The event gave us an opportunity to celebrate all that is great about RDaSH care, services and staff, with a fantastic response of over 200 nominations across the 10 categories received from services across the Trust’s footprint. The awards include categories for each of the three Trust quality priorities and commends staff that have made an exceptional contribution, along with a Quality Care Award that is exclusively nominated by patients, services users and carers. Further details on the winners and runners up of these awards can be seen in Section 2a.

If we are to face the challenges that are heading our way, both following the Francis Report and its focus on NHS Quality and in the light of the financial position the Trust will find itself working within, we need staff who feel they are part of an organisation that values them, supports them and provides the environment in which they can do their best. Change is probably the only certainty in our future and the creation of an organisation and a staff team that can respond to those changes cannot be achieved from a top down approach alone. To support these challenges the Trust launched our ‘Fit 4 the Future’ (F4F) Leadership Development Programme, engaging over 300 leaders in the organisation in debate and development to support our roles moving forward.
To build on F4F a wider series of ‘Leading the Way with Quality’ workshops for all staff groups has focussed on culture and what makes RDaSH ‘tick’. Culture is a complex product of many things – communication, values, rewards, involvement, attitude, fun, the modelling of behaviours that show respect, and positive engagement. Over 400 staff have joined me at these workshops to review the role that culture plays in the organisation and to discuss how we can make it productive and positive.

We have implemented our plans for 2013/14, along with the service redesigns and reviews that accompany them. Commissioners are holding us to account for the delivery of our services in a more robust way than before. The Francis report and the Berwick report into Patient Safety require us to review the way we handle quality issues in the Trust and our Quality, Innovation, Productivity and Prevention (QIPP) plans for 2014/15 have been formulated. In December 2013, we published our response to the Francis Declaration on our website, which details work already completed and our future action plan of work to implement the recommendations from the Francis Report. It was jointly signed off by our Board of Directors and Council of Governors.

In October 2013, we were visited by inspectors from the Care Quality Commission (CQC) who conducted thorough inspections of both our services and our governance processes. If you had the opportunity to talk with the inspectors then my thanks for providing them with the opportunity to meet you, answer their questions and provide a view as to how our services, systems and processes work in practice. We received a very positive report from the CQC, showing that we meet all the standards expected of us in relation to the quality outcomes they investigated during their visit. Its contents will be an important source of information and feedback for us to continue to improve our offer to patients and service users and to review how we deliver our services and support.

The CQC inspectors asked some very challenging questions. One of the areas they probed was how do we as Board members assure ourselves what is happening day to day on the front line of our services? I talked to them about all the ways we do that, the arrangements we have in place for quality governance and assurance and the visits and involvement we have with services on a regular basis. The inspectors also asked how confident I was, that staff knew how to raise concerns and felt able to do so. I discussed all the work that we have done with teams about the Trusts quality strategy, our quality objectives, our vision ‘Leading the Way with Care’, F4F and our approaches to raising concerns and whistleblowing. I know that when the CQC asked staff on our wards and in services, many staff also confirmed this view.
During the year we have also had a number of quality challenges to deal with, which have led to improvement plans and actions being agreed with our Commissioners.

- In Rotherham, the Clinical Commissioning Group identified a number of performance and quality shortfalls in our Childrens and Young Peoples Services, which resulted in a lack of confidence being expressed by General Practitioner colleagues in our services. A detailed action plan has been implemented and improvements have been made, however there is still more work to be done to embed these changes;

- In Doncaster, a number of quality concerns were highlighted through our own governance processes relating to Adult Mental Health Services. A detailed plan of action focusing on care planning, communication and risk management, particularly in ward areas and at the interface of inpatient and community services has been implemented. A fundamental review of services has also been undertaken by our Commissioner and a joint approach to service redesign and improvement is underway;

- In North Lincolnshire, work has been completed on reviewing and implementing a new management and senior leadership structure across adult mental health services and strengthening our approach to risk management and care planning. Work is underway with North Lincolnshire service users and the local Healthwatch to embed these improvements.

Overall, our approach to quality governance has been shown to be robust and has enabled us to respond to issues promptly.

On the governance front, we have appointed a new Chairman, Lawson Pater, who took up post in December 2013 when Madeleine Keyworth retired, we also appointed two new Non-Executive Directors to our Board.

So, overall…how are we doing? Well, my summary is that we are on the right track, and although our path looks somewhat steeper in the future we are as well placed as any Trust to tackle what lies ahead. The important thing is that we keep our lines of communication open, continue to open our minds to learning from our challenges and remember that ‘Leading the Way with Care’ is what we do around here.

As the Chief Executive of Rotherham Doncaster and South Humber NHS Foundation Trust, I can confirm that, to the best of my knowledge, the information contained within this document is accurate.

Our annual report 2013/14 contains further information about our performance over the past year, as well as a summary of our financial accounts. For more details please contact the Communications Team on telephone 01302 796204 or email RDaSHCommunications@rdash.nhs.uk
Part 2a – Priorities for improvement 2013/14

2. A look back at the year 2013/14 - performance against quality improvement priorities

The three quality improvement priorities for 2013/14, identified within the 2012/13 Quality Report, were as follows:

- Personalised care
- Record keeping
- Clinical leadership

The quality improvement priorities were set by the Board of Directors and the Council of Governors. The priorities were first identified in the 2011/12 Quality Report and progress has been reported on an annual basis. The programmes of work associated with each of the priorities have principally been delivered through quality markers agreed with each of the Trust's business divisions and have been supported by the Quality Improvement Team (QIT) and the records manager.

The progress and outcomes of the work on the quality priorities for 2013/14 is summarised below:

3. Personalised care

Each business division identified a quality marker for 2013/14 for improving personalised care, specific to the identified improvement needs of their services. A selection of service specific examples of improvement are provided below:

- All inpatient staff within the Adult Mental Health business division have undertaken personalised care planning (PCP) training and have worked with patients and carers to raise awareness. Audit has shown that there is increased patient and carer input into care plans.
- A new care plan format has been introduced in the Forensic business division and has received positive feedback following a recent CQC Mental Health Act monitoring visit.
- The Learning Disabilities business division has improved the quality and availability of accessible information. The business division was highly commended in a national award for easy-read information and a group has been established to continue reviewing the quality of communications to service users.
- The Drug and Alcohol Services business division care plan audits, evidence that there is an increase in patient involvement in their care plans and that there has been an increase in the delivery of recovery focussed interventions.

Our services that have been subject to CQC inspection since July 2012 have been assessed as ‘compliant’ with the CQC standards for care planning and record keeping, when reviewed. In 2012/13, two CQC inspections identified ‘minor’ compliance actions for ‘records’, and one inspection identified a ‘minor’ compliance action for ‘respecting and involving people who use services’. Action plans were completed and the services were reinspected and assessed as ‘compliant’ with both standards.
4. Record Keeping

Personalised care is evidenced through good record keeping. Since the post was established in July 2012, the records manager has worked with individual staff and teams and made improvements in the following priority areas:

- Production and implementation of Safe Haven Policy, Retention and Disposal Policy and a Moving Premises Package.
- A revised Records Management Induction
- A refresher records management session for existing staff has been developed to support staff in their clinical roles.
- A Corporate Templates Repository has been initiated to provide consistency in the standard of records used throughout the Trust.
- Records Management Co-ordinators have been identified to implement the records management work streams in their service areas.

5. Clinical Leadership

The Trust has commissioned an organisational development programme ‘Fit 4 the Future’ (F4F). 304 staff, band seven and above, from across the Trust attended, including 217 senior clinicians. The modules were dedicated to quality, innovation, culture and leadership:

- Module 1 – Engaging your team for success
- Module 2 – Engaging your team in quality services
- Module 3 – Leading your team through change
- Module 4 – Leading in partnership
- Module 5 – Inspiring your team and promoting your service

A final half day ‘celebration and where next’ event is being planned for quarter 1, 2014/15. The Chief Executive relaunched the ‘Leading the Way with Quality’ workshops in February and March 2014. The workshops cascaded some of the thinking and activities from F4F and enabled other staff to engage in the programme. Positive feedback has been received, with staff finding that the sessions gave plenty of opportunity for interaction through the activities, they were listened to and staff felt that they are valued. In addition, a range of short workshops have been made available covering topics such as:

- Change management
- Personal effectiveness
6. Annual Awards Ceremony

The Annual Members Meeting and Award Ceremony was held on 25 September 2013 and once again showcased the excellent work that is happening across the Trust. The awards include categories for each of the three Trust priorities and commend staff that have made an exceptional contribution to the Trust’s vision statement of ‘Leading the Way with Care’ as well as a Quality Care Award that is exclusively nominated by patients, services users and carers. Winners and runners up for this year’s awards were as follows:

**Leadership**

- Vikki Sullivan, Occupational Therapist, Manchester Early Intervention in Psychosis (EIP) - Winner

“Vikki has collaborated with clinicians to develop an accessible care pathway for first episode psychosis clients. She has made links with safeguarding adults and children’s services, promoting supervision, offering guidance and navigating IT systems.

She set up a working group to write and design pages for the Manchester EIP pages of the RDaSH website, involving clients in a photography group to gather images. Vikki delivers her role in a dignified, thoughtful, sensitive and intelligent manner.”

- Les Monks, East Dene, Doncaster – Runner Up

“Les Monks was seconded to East Dene in Doncaster to manage the Community Therapies Team.

Les has been in post for only a few months, during which time he has adopted an inclusive and shared leadership style. His maturity and ‘solid’ personality reflect the strengths needed to manage a team in the midst of change.

The team have transformed themselves under his leadership into an effective, dynamic and innovative clinical team. His leadership and management style are an inspiration to his staff and he has won their confidence and respect.”

**Personalised Care**

- Wheelchair and Special Seating Service, Doncaster - Winner

“The Wheelchair and Special Seating service supports approximately 9,000 children and adults in Doncaster with their mobility and postural needs.

Patient and carers have commented that staff actively listen to concerns and make every effort to ensure that the chair is appropriate for the person. They feel involved and valued by being given time to ask questions and gain confidence in the use of the chair.”

- Vicki Brown, Rotherham and Holly Newton, Scunthorpe, Occupational Therapy Service – Runners Up

“Occupational Therapists Vicki, who is based in Rotherham and Holly, who is based in Scunthorpe participated in the first phase of Valuing Active Life in Dementia (VALID).

This is an important international occupational therapy research project for people with dementia and their family and carers. Vicki and Holly have shown great enthusiasm, resourcefulness and resilience in the training and tasks required for the project - and have done this alongside their busy clinical roles.”
Record Keeping

- Community Assessment and Intensive Support (CAIS) Team and Sapphire Lodge Learning Disabilities Service, Doncaster - Winners

“These clinical teams developed the accessible Proactive Risk Management Plans that are person centred plans specifically designed to support the proactive management of risks associated with challenging behaviour.

The plans were developed by professionals in collaboration with service users, their families and advocates feedback has been very positive”.

- Wendy Batchelor and Lorraine Preston, Drug and Alcohol Services Services, Scunthorpe – Runners Up

“Wendy and Lorraine work as administrative staff across two sites at The Junction and the Community Alcohol Service in Scunthorpe.

During the last year the service has implemented a new case management system, the changeover period has involved a lot of extra work for administrative staff and has led to dramatic changes to processes and procedures. Administrators in the service are now up to date and more accurate due to the hard work and dedication of these staff members”

Quality Care Award

- Community Memory Therapy Service, Doncaster - Winner

“The service was nominated by the wife of a service user. The service user went to cognitive therapy units which helped to keep him motivated and happy. The therapy ranged from trips to the seaside to visits from school children. He mixed with similar patients and met other carers who also gave support.

The clinic also ran six useful lectures about finance, power of attorney, making a will, how to deal with service users in stressful situations and when to go for help.”

- Rachel Matharoo, Peer Support Worker, Children and Young People’s Mental Health Services, Doncaster – Runner Up

“The parent who made this nomination said that without Rachel and CAMHS their son would not be where he is today. CAMHS have been very supportive of both parent and child, understanding, very patient and non-judgmental, making numerous appointments with various people to help with his difficulties. Because of this the child has now started studying at the Deaf College.”
7. Local Commissioning Priorities

During 2013/14 we have had a number of quality challenges to deal with, which have led to improvement plans and actions being agreed with our commissioners and monitored through the locality Contract Monitoring meetings:

**Rotherham**

The Clinical Commissioning Group identified a number of performance and quality shortfalls in our Children’s and Young People’s Mental Health services, which resulted in reduced confidence being expressed by General Practitioner colleagues in our services. A detailed action plan has been implemented and improvements have been made. Initial indications are that significant progress has been made by working in partnership with commissioners in delivering the improvements to this service. Feedback from the GP survey as part of the action plan has been positive and the action plan has been signed off. However, it is acknowledged that there is still more work to be done to fully embed these changes and work will continue in 2014/15.

**Doncaster**

A number of quality concerns were highlighted through our own governance processes relating to Adult Mental Health services. A detailed plan of action focusing on care planning, communication and risk management, particularly in ward areas and at the interface of inpatient and community services has been implemented. A fundamental review of services has also been undertaken by the Clinical Commissioning Group and a joint approach to service redesign and improvement is underway.

**North Lincolnshire**

Work has been completed on reviewing and implementing a new management and senior leadership structure across Adult Mental Health services and strengthening our approach to risk management and care planning. Work is underway with North Lincolnshire service users and the local Healthwatch to embed these improvements.

Rotherham's young psychosis sufferers' conference, pictured from left are Mayoress of Rotherham Kath Foden; Mayor of Rotherham Councillor John Foden, RDaSH Principal Practitioner David McMullan and RDaSH Chief Executive Christine Bain
8. Progress with business division quality markers 2013/14

The Trust business divisions have identified quality markers linked to the Trust quality priorities for 2013/14. Some examples of progress against the business division quality markers for 2013/14 is summarised in table 1:

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<td><strong>Personalised care planning</strong></td>
<td>All inpatient staff within the Adult Mental Health business division have undertaken PCP training and have worked with patients and carers to raise awareness. Audit has shown that there is increased patient and carer input into care plans.</td>
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<tr>
<td><strong>Collaborative work with patients to improve care plans</strong></td>
<td>A new care plan format has been introduced in the Forensic business division and has received the following positive feedback following a recent CQC Mental Health Act monitoring visit; “patients were involved in their care planning process in a way that enabled them to talk to us about it.”</td>
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<td><strong>Improve service pathways</strong></td>
<td>The Doncaster Community Integrated Service (DCIS) business division has recruited two telehealth nurses for the long term conditions pathway and funding has been secured for telehealth equipment from the NHS England Nursing Technology Fund to allow patients to access telemonitoring seven days a week.</td>
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<td><strong>Copying care plans to patients</strong></td>
<td>The Older People’s Mental Health business division patient experience survey shows improved results with 86.3% of patients reporting that they were copied into their personalised care plan, and 100% of respondents reported that they were offered therapeutic activities indicating that patient activities are embedded as core in inpatient services.</td>
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<td><strong>Improve experience of transitions to other services</strong></td>
<td>Leaflets on transitions have been produced and the Peer Support Workers (PSWs) in the Child and Adolescent Mental Health Services (CAMHS) business division are improving the transition experience. Service user evaluation of the benefits of the PSW role has been positive.</td>
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<td><strong>Record keeping</strong></td>
<td>An Integrated Record System is now in place in the Forensic business division and positive feedback has been received following the 90 day Quality Improvement Team (QIT) check.</td>
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<td><strong>Improve record keeping</strong></td>
<td>The record keeping audit shows that there have been improvements in the Adult Mental Health business division.</td>
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<td><strong>Clinical leadership</strong></td>
<td>The Forensic business division has commenced Reflective Practice Groups, and the quality of supervision is monitored by the Modern Matron and the Ward Manager.</td>
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<td><strong>Staff responsibility to raise concerns</strong></td>
<td>All senior staff have undertaken Personal Responsibility training in the Learning Disabilities business division and this is now being cascaded to more staff. Random snapshot telephone survey conducted to assess staff awareness of how to raise concerns, 95% of answers were correct and clear. All staff completed survey to follow up. 99% of staff aware of procedure.</td>
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<td><strong>Leaders embed a ’Quality Culture’</strong></td>
<td>The Drug and Alcohol Services business division has held a third reflective practice event regarding the Francis Report. Leaders have identified ways to make cultural changes, increased ownership of quality reporting for all leaders across the business division.</td>
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<td><strong>Improve the quality and availability of clinical supervision</strong></td>
<td>The DCIS business division has set up dedicated clinical supervision groups for each service and increased the number of trained supervisors across the business division.</td>
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</table>
9. Progress with User Carer Partnership Council (UCPC) quality markers 2013/14

The User Carer Partnership Council (UCPC) quality markers were signed off for 2013/14 at the final meeting of the UCPC in November 2013. The UCPC service users and carers will be able to engage with the Adult Mental Health business division through the locality collaborative meetings.

10. Trust Business Division Governance Framework 2013/14

The Business Division Performance Reviews are informed by risks highlighted based on a dashboard of Key Performance Indicators (KPIs) in each of the four areas of the Business Division Governance Framework. These four areas are

- ‘Finance Efficiency and Business Strategy’,
- ‘Quality and Standards’,
- ‘Our People/ Our Staff’ and
- ‘Service Performance and Risk’.

RAG ratings are applied based on the review period data and, in addition, any significant information available for the review referenced.

Each of the Trust’s seven business divisions took part in a mid-year performance review meeting between 12 November and 16 December 2013. The reviews focused on performance during Quarters 1 and 2, 2013/14. Outlined in table 2 are the ratings given in the domain of ‘Quality and Standards’ since the Mid-Year Reviews in 2012/13 to allow comparison, in line with the scope of this report. A further set of reviews are scheduled for June 2014 to review performance throughout 2013/14.

<table>
<thead>
<tr>
<th>Business division</th>
<th>Mid Year 2012/13</th>
<th>Quarter 3 2012/13</th>
<th>Quarter 4 2012/13</th>
<th>Mid Year 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forensic</td>
<td>Red</td>
<td>Red</td>
<td>Red</td>
<td>Amber/Red</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Green</td>
<td>No Review Required</td>
<td>Amber/Red</td>
<td>Amber/Green</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>Green</td>
<td>No Review Required</td>
<td>Green</td>
<td>Green</td>
</tr>
<tr>
<td>Older People</td>
<td>Amber/Green</td>
<td>Amber/Green</td>
<td>Green</td>
<td>Amber/Green</td>
</tr>
<tr>
<td>Substance Misuse</td>
<td>Amber/Green</td>
<td>No Review Required</td>
<td>Amber/Green</td>
<td>Amber/Green</td>
</tr>
<tr>
<td>Adults</td>
<td>Amber/Green</td>
<td>Amber/Green</td>
<td>Amber/Green</td>
<td>Amber/Red</td>
</tr>
<tr>
<td>DCIS</td>
<td>Amber/Green</td>
<td>Green</td>
<td>Green</td>
<td>Amber/Green</td>
</tr>
</tbody>
</table>

A robust improvement plan was put in place to address a number of areas spanning quality, finance, performance and human resources in the Forensic business division and has been supported by the Quality Improvement Team. The plan is monitored through the Trust and the Forensic business division Clinical Governance Group, and as shown in the mid-year review some improvements have been made.
11. The Trust’s response to Francis, Berwick and Keogh

The Trust produced a response to the Francis Inquiry and to the two Government responses, which details the changes that have taken place within the Trust to address the issues raised, and also highlights areas where further improvement is still required.

The Trust’s Francis Declaration was developed jointly by the Board of Directors and the Council of Governors representatives and jointly signed off by the Board of Directors and the Council of Governors at a public Board of Directors meeting, prior to publication on the Trust website at http://www.rdash.nhs.uk/corporate-information/public-declarations/francis-report/.

The Francis Declaration focusses on:

- Our Quality Journey
- Trust Response to ‘Hard Truths: The Journey to Putting Patients First’
- Francis Priorities for 2014/15
- Board of Director and Council of Governor Statement

In developing the Trust’s quality improvement approach and the Francis Declaration, RDaSH has also taken the following national independent reports into consideration through its governance processes:

- Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England, led by Professor Sir Bruce Keogh, the NHS Medical Director in NHS England
- A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England, by Professor Don Berwick
- A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture by Rt Hon Ann Clwyd MP and Professor Tricia Hart
- Challenging Bureaucracy, led by the NHS Confederation.
- The report by the Children and Young People’s Health Outcomes Forum, co-chaired by Professor Ian Lewis and Christine Lenehan.

Based on the recommendations from the Francis Inquiry the Board of Directors has identified four Francis priorities for further development and consideration over the next 12 months:

- Culture - the organisational development programme “Fit 4 the Future” includes a module dedicated to culture and analysis of the results of the annual staff survey.
- Engagement – the “Leading the Way with Quality” workshops in Spring 2014 cascaded the thinking from the Fit 4 the Future programme and completed some work together on refreshing the Trust’s values. The professional networks are contributing to the refreshed professional strategy in the light of the recommendations from the Francis Report.
- Non-professionally qualified staff – the Trust is taking part in the pilot programme for a certificate on fundamental care and apprenticeships for non-qualified staff and contributing to the national agenda.
- Supporting whistleblowing - refreshed policy and ongoing promotion campaign.

The Board of Directors and Council of Governors endorsed the Trust Francis Declaration by stating:

‘The Board, Governors and staff pursue the ongoing development of a culture that:

- Puts the patient at the heart of everything we do
- Supports and develops our staff to deliver positive care
- Delivers continuous improvement’

A mid-year review of progress will be considered by the Board of Directors and Council of Governors during 2014.
12. Strategic context

The Trust’s Strategic Objectives define the approach we are taking to deliver our Vision of ‘Leading the Way with Care’. Our Strategic Objectives and the associated workstreams have been refreshed for 2014/15, taking into account national guidance and recommendations, such as the Francis Report, the Berwick and Keogh Reports and the revised CQC inspection regime. The Strategic Objectives have stood us in good stead, remain valid and also take into consideration the challenging financial and competitive environment in which the Trust is working. Therefore in 2014/15 the Trust’s Strategic Objectives will be:

- Continuously improve service quality (safety, effectiveness and patient experience) for our patients and carers
- Nurture the talent, commitment and ideas of our staff in order to deliver excellent services
- Ensure value for money and increased organisational efficiency whilst maintaining quality
- Adapt and deliver services to meet agreed commissioned needs through enhanced multi-agency partnerships
- Maintain excellent performance and governance and a strong market position; and improve further our reputation for quality.

13. Priorities for quality improvement 2014/15

The Trust commenced its quality journey in July 2011. This followed the lessons learned from the investigations into a number of incidents and from inspections, which included CQC inspections identifying further quality concerns relating principally to personalised care and record keeping. Subsequent internal actions revealed concerns about clinical leadership, which led to the Trust identifying its top three quality improvement priorities within its quality strategy for 2011/12 and 2012/13 as:

- Personalised care
- Record keeping
- Clinical leadership

Following approval by the Board of Directors in January 2012, the Quality Improvement Team (QIT) was established as a two year project to support the sustainable implementation of the three quality priorities and the delivery of the quality improvement programme identified in the Quality Marker schemes.
Building on the improvements we have achieved in 2012/13 and 2013/14 and our assessment of quality performance during 2013/14 the Trust has been able to refocus its quality priorities from three to one for 2014/15; **Leadership**.

This is based on a fully compliant CQC inspection of Trust services in October 2013 and being fully compliant with the Essential Standards of Quality and Safety inspected by the CQC since July 2012, including care planning and record keeping. In addition, assurance has been taken from other external and internal inspections, including outcomes from the Clinical Commissioning Group quality visits, Health and Safety Executive, Clinical Audit and the Quality Improvement Team.

To support the quality priority, the Trust has commissioned an organisational development programme ‘Fit 4 the Future’, which includes modules dedicated to quality, innovation, culture and leadership. This quality priority is aligned to the Strategic Goal of ‘Continuously improving service quality (safety, effectiveness and patient experience) for our patients and carers’.

A clinical staffing review group has been formed, to respond to the national recommendation that NHS trusts have the right staff, with the right skills, in the right place. The Trust will be reporting staffing levels from June 2014. There is key representation from each business division to develop and implement the staffing review for both inpatient and community services where relevant. An inpatient escalation process focusses on acuity and dependency levels, aligning the staffing review with the quality impact assessment process and benchmarking against best practice, nationally.

The views of patients and carers, our staff and the wider public have been taken into account in agreeing our priorities in some of the following ways:

- Council of Governors whose membership comprises patients, carers, public and partner governors
- Discussions at locality patient and carer groups such as the mental health collaboratives
- Feedback provided by patients and carers through the national and local experience surveys
- Feedback provided by patients and carers through CQC inspections and CQC Mental Health Act monitoring visits
- Feedback provided by GPs through local surveys
- Discussions with local HealthWatch
- Attendance at local health economy groups such as the Health and Wellbeing Boards
- ‘Leading the Way with Quality’ workshops for staff
- Discussions at the Trust professional network groups
- External and internal visits to discuss and review quality issues with teams/staff

We will keep this priority for quality improvement under review throughout the year to ensure it remains current and responsive, based on the outcomes of the work of the Quality Improvement Team and any other emergent priorities.

Measurement of the quality improvement priority will be achieved through the quality markers for 2014/15, set within the quality domains of patient experience, patient safety and clinical effectiveness that have been agreed with each of the Trust’s business divisions. Progress against the quality markers will be monitored through the Clinical Effectiveness Committee and reported in the quarterly Quality Improvement Report.
14. Trust Business Divisions’ Quality Markers

For 2014/15 the business divisions have agreed quality markers set within the domains of quality:

- Patient experience
- Patient safety
- Clinical effectiveness.

The quality markers are also linked, where required, to the business divisions’ self-assessment against the CQC essential standards of quality and safety. The quality markers have clear outcomes and measurements and are discussed regularly at business division and team meetings. An example of a business divisions quality markers for 2014/15 is shown in table 3:

<table>
<thead>
<tr>
<th>Table 3 Business division quality markers 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Business division</strong></td>
</tr>
<tr>
<td>• Adult Mental Health</td>
</tr>
<tr>
<td><strong>Patient Experience</strong></td>
</tr>
<tr>
<td>• The Adult Mental Health business division meets the six key standards of the carer’s ‘Triangle of Care’</td>
</tr>
<tr>
<td><strong>Patient Safety</strong></td>
</tr>
<tr>
<td>• Service users will access clinical pathways relevant to their needs and waiting times will be within commissioned thresholds</td>
</tr>
<tr>
<td><strong>Clinical Effectiveness</strong></td>
</tr>
<tr>
<td>• The Adult Mental Health business division will have clearly defined roles and responsibilities for its clinical and managerial staff</td>
</tr>
</tbody>
</table>

15. Patient, carer and public engagement and feedback

During 2013/14, the refreshed Patient Carer and Public Engagement and Experience (PPEE) Strategy - ‘Listen to Learn’ was launched. The Listen to Learn Steering Group was also established to implement the strategy and to further develop engagement with patients, carers and the public. Patients, carers and Governors are members of the Listen to Learn Steering Group and are working with business divisions to develop plans to further improve engagement and feedback, which will be measured using the “ladder of participation”.

‘Listen to Learn’ is a key component of our overall quality strategy, and we will ensure that we act on feedback as effectively as we can and that it informs all the work that we do. Feedback from patient and carer surveys, complaints and PALs etc. will continue to be reported and shared through our Quality Improvement Report.
16. Collaborative working with commissioners

Collaborative working with commissioners will continue to be an important priority for the Trust during 2014/15, for all services.

The national and local commissioning priorities have become increasingly competitive and quality orientated. It can no longer be assumed that NHS provided care is the first or most optimal solution for commissioners to meet the needs of their populations. The Trust must be able to compete and demonstrate that it can operate efficiently, to high standards of care and in line with commissioner expectations.

National commissioning priorities that the Trust will be involved with include:

- CAMHS Inpatient Services (Tier 4) – the Trust is submitting information to the Health Select Committee Review of the provision of Tier 4 CAMHS. The Trust will work with commissioners to implement the recommendations following the completion of the review.
- 7 Day Working – the Trust currently provides some 7 Day Working services and is working with commissioners to develop further services over the next three years, taking into account the 10 national clinical standards.
- Better Care Fund – engaged in local health economy plans for development of the fund.
- Closing the Gap – the Trust is working with Commissioners over the next two years to bridge the gap between long-term ambitions for mental health and shorter-term actions. The Trust will work with each local health economy to demonstrate changes in the 25 areas where the most immediate change and improvement is expected, and to deliver outcomes aligned to the Parity of Esteem principle of providing equitable access to mental health and physical health services for people with both mental health and physical health needs. Recent commissioner led reviews of the mental health services have resulted in an expressed intention from commissioners to support the Trust to work more closely with General Practices to build capacity and capability to meet the mental health needs of the community, on a whole system basis.

Public health commissioning priorities that the Trust will be involved with include:

- Provision of Drug and Alcohol Services services and possible retendering of services
- Provision of Contraception and Sexual Health Services
- Provision of School Nursing

Local commissioning priorities that the Trust will be working on include:

**Doncaster**

The development of:

- The mental health crisis pathway
- A case management approach for community nursing
- Local specialist pathways
- The new memory service pathway
- Care pathways and packages (Mental Health Payment and Pricing Systems)

A review of the:

- Unplanned care system
- Children’s community nursing service

And also include:

- Joint commissioning of Learning Disabilities Assessment and Treatment Unit
- Utilising capacity within Older People’s Mental Health inpatient services to meet more complex needs
Rotherham
Consideration of investment in priority areas following the outcomes of the reviews, as detailed below:
• Mental health and learning disability services
• Learning Disabilities Assessment and Treatment Unit and community services
• A comprehensive CAMHS strategy
• Development of care pathways and packages (Mental Health Payment and Pricing Systems)

North Lincolnshire
The development of:
• A potential specialist Learning Disabilities service
• Care pathways and packages

The Trust aims to keep ahead of its competitors in terms of quality and patient experience, by working flexibly and imaginatively to deliver care in ways that are innovative and transformational.

17. Monitor’s risk assessment framework
Monitor is the external regulator of NHS Foundation Trusts. The key governance targets set by Monitor’s risk assessment framework for 2014/15, which support the Trust’s quality improvement plans, are shown in Tables 4 and 5:

<table>
<thead>
<tr>
<th>Table 4 Monitor’s Mental Health and Learning Disability compliance framework targets for 2014/15</th>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care programme approach: Follow-up contact within 7 days of discharge</td>
<td>95%</td>
</tr>
<tr>
<td>Care programme approach: Having formal review within 12 months</td>
<td>95%</td>
</tr>
<tr>
<td>Admissions to inpatients services has access to crisis resolution/home treatment teams</td>
<td>95%</td>
</tr>
<tr>
<td>Meeting commitment to service new psychosis cases by early intervention</td>
<td>95%</td>
</tr>
<tr>
<td>Minimising delayed transfers of care</td>
<td>&lt;= 7.5%</td>
</tr>
<tr>
<td>Data completeness identifiers</td>
<td>97%</td>
</tr>
<tr>
<td>Data completeness: outcomes for patients on CPA</td>
<td>50%</td>
</tr>
<tr>
<td>Certification against compliance with requirements regarding access to health care for people with a learning disability</td>
<td>n/a</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 5 Monitor’s Community Services compliance framework targets for 2014/15</th>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral to treatment information</td>
<td>50%</td>
</tr>
<tr>
<td>Referral information</td>
<td>50%</td>
</tr>
<tr>
<td>Treatment activity information</td>
<td>50%</td>
</tr>
</tbody>
</table>
18. Commissioning for Quality and Innovation (CQUIN) payment framework

In 2014/15, 2.5% of the Trust’s income will be conditional on achieving quality improvement and innovation goals agreed with our commissioners, through the CQUIN payment framework. Tables 6-8 show the 2014/15 CQUIN schemes for Community, Mental Health and Learning Disability and Forensic services.

Table 6 Community Services CQUIN indicator framework for 2014/15

- National Safety Thermometer (national indicator)
- Friends and family test (national indicator)
- Patient and Carer Experience
- Dementia Community
- Community Nursing and One Team Working
- Safeguarding
- Supporting Breastfeeding
- Building Community Capacity

Table 7 Mental Health and Learning Disability Services CQUIN indicator framework for 2014/15

- Patient and Carer Experience
- NHS Safety Thermometer (national indicator)
- Transition Planning
- Recovery (Discharge and Planning)

Table 8 Forensic Services CQUIN indicator framework for 2014/15

- Friends and family test (national indicator)
- Improving physical healthcare to reduce premature mortality in people with severe mental illness (SMI) (national indicator)
- Safeguarding
- Collaborative Risk Assessments
- Supporting Carer Involvement
- Service User formulation of need at transition
- Quality Dashboard
19. Clinical audit

We will continue to develop the use of clinical audit during 2014/15 to improve patient care and to make sure that improvements are implemented and sustained. Our clinical audit strategy and annual clinical audit programme are shaped by our strategic priorities, national and local expectations and prioritises local concerns. As such, clinical audit is a crucial component of our quality strategy.

During 2013/14 Internal Audit conducted a review of clinical audit to provide assurance over the effectiveness of planning and organisational learning. The review found that ‘significant assurance’ can be provided from the clinical audit process. There were two minor recommendations that will be implemented during 2014/15 and the increasingly systematic use of clinical audit during 2014/15 will enable us to measure and improve the quality of care patients receive against evidence based standards and to further quantify the improvements made. It will also provide us with a measure of how well we are implementing our key risk management policies and identifies where policies can be improved to provide clearer procedural guidance for staff.

Used in conjunction with a number of related processes such as significant event enquiries, patient surveys, internal audit and measurable quality markers, clinical audit will provide a framework for measurement of quality improvement.

This work will be supported and driven forward by the Quality Improvement Team, working collaboratively with the business divisions.

20. Monitoring and measuring progress and reporting on quality

The committees and groups within the Trust’s governance structure meet on a regular basis to review plans for quality improvement, challenge areas of concern and manage in-year issues. Performance against key quality measures is reported to and monitored by the:

- Council of Governors (CoG)
- Board of Directors (BoD)
- Clinical Governance Group (CGG)
- Performance and Assurance Group (PAG)
- Organisational Learning Forum (OLF)
- Business Division Clinical Governance meetings
- Audit Committee

and externally to our commissioners via the Quality Review Group and the contract monitoring meetings. Quality priorities and issues are raised with staff through:

- Monthly Quality Matters bulletin
- Chief Executive Blog
- Trust Matters
- Professional Forums such as Nursing Network and the Allied Health Professionals Forum
- Leading the Way with Quality workshops
- Team meetings
In addition, the Trust works collaboratively with a number of patient and carer groups in each of the localities in which the Trust provides services, who play a key role in providing us with feedback and challenge and in monitoring quality improvement. The Trust has reviewed its patient engagement approach and produced a new Listen to Learn Strategy. The implementation of this strategy is overseen by a steering group comprised of:

- Governors
- Trust members
- Representatives from patient and carer groups
- Representatives from each Healthwatch for the Trust’s localities
- Representatives from each business division

The quarterly Quality Improvement Report is produced to analyse quality and report on performance against the key priorities, quality markers, CQUINs and the three domains of quality. The information from each of the sections of the Quality Improvement Report is triangulated in the Conclusion section, and using the early warning indicators implemented by the Trust, services that have hit the early warning trigger points are highlighted. Actions to be taken are agreed by the CGG and followed up at the next meeting. Examples of the early warning system being triggered are the rising trend in the number of suicides in Adult Mental Health services and the rise in the number of pressure ulcers in Doncaster Community Integrated Services, and the approach taken to conduct monthly thematic and quantitative deep dives and to monitor progress against the quality improvements actions to address these areas and the lessons learned.

The quarterly Quality Improvement Report supports the delivery of the Trust’s Strategic Objectives, annual Quality Report, the Trust’s quarterly self-assessment against Monitor’s Quality Governance Framework and the forthcoming three-yearly Governance Reviews, and the embedding of the CQC Essential Standards (to be replaced by the CQC Fundamental Standards in 2014/15). In addition, the business divisions’ performance, including quality improvement work, is reviewed by the Senior Leadership Team and outcomes reported to the Board. Where progress is not sufficient, improvement actions are agreed and progress towards achievement is monitored. In addition, a bespoke Quality Improvement Report is presented to every Council of Governors meeting.

In November 2013 a revised approach to presenting performance information to the Board of Directors was agreed. The two Service Directorates produce a one page performance dashboard for each of their business divisions. The dashboard is presented to the Performance and Assurance Group on a monthly basis for analysis and discussion. The dashboards are then presented to the Board of Directors with the focus on performance exceptions highlighted by the Performance and Assurance Group.

Key risks to quality are also identified and monitored through other internal quality monitoring processes including:

- Quality Impact Assessment (QIA) - supports the quality innovation productivity and prevention (QIPP) process. All QIPP plans are assessed on their quality impact, with the more complex schemes assessed using the Birmingham QIA tool and are signed off by the Director of Nursing and the Medical Director.

- Quality Risk Profile – in 2013/14 the Trust has piloted a Quality Risk Profile (QRP). The QRP is business division specific and includes quality risks in the areas of patient safety, clinical effectiveness, patient experience and other areas for consideration, including regulatory and stakeholder concerns. The Trust continues to develop this process and in 2014/15 the quarterly QRP will include monitoring of the QIPP schemes.

RDaSH has performed well in achieving its quality priorities and indicators for patients in 2013/14 and the Trust is aspiring to continue achieving the quality priorities and indicators for patients in 2014/15.
21. Review of services

During 2013/14 Rotherham Doncaster and South Humber NHS Foundation Trust provided and/or sub-contracted 106 relevant health services.

Rotherham Doncaster and South Humber NHS Foundation Trust has reviewed all the data available to them on the quality of care across all of the business divisions and all 106 of these relevant health services.

The income generated by the relevant health services reviewed in 2013/14 represents 100 per cent of the total income generated from the provision of relevant health services by Rotherham Doncaster and South Humber NHS Foundation Trust for 2013/14.

Further details of the services provided/sub-contracted by RDaSH are provided on the trust’s website at: http://www.rdash.nhs.uk/services/our-services/

All business divisions review information on a monthly basis relating to the performance of their services, the quality of care provided including clinical effectiveness, patient safety and patient experience. The review measures progress against quality improvement priorities and actions are taken, as required. Business divisions also work with corporate services to validate information relating to services and quality and where planned or appropriate, data quality is tested. Examples of data quality are included in the performance indicators included in the three domains of quality in part 3.

22. Participation in clinical audits

During 2013/14 seven national clinical audits and one national confidential inquiry covered relevant health services that Rotherham Doncaster and South Humber NHS Foundation Trust provides.

During 2013/14 Rotherham Doncaster and South Humber NHS Foundation Trust participated in 100% clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Rotherham Doncaster and South Humber NHS Foundation Trust was eligible to participate in during 2013/14 are as follows:

National Clinical Audits
- National Audit of Schizophrenia
- National Audit of Psychological Therapies for Anxiety and Depression
- National Audit of Intermediate Care
- Prescribing Observatory for Mental Health UK (POMH-UK) (3 clinical audits)

National Confidential Inquiry
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

The national clinical audits and national confidential enquiries that Rotherham Doncaster and South Humber NHS Foundation Trust participated in during 2013/14 are as follows:

National Clinical Audits
- National Audit of Schizophrenia
- National Audit of Psychological Therapies for Anxiety and Depression
- National Audit of Intermediate Care

POMH-UK Audits
- Prescribing for ADHD
- Monitoring of Patients prescribed Lithium
- Prescribing Anti-Dementia Drugs
National Confidential Inquiry
• National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

The national clinical audits and national confidential enquiries that Rotherham Doncaster and South Humber NHS Foundation Trust participated in, and for which data collection was completed during 2013/14, are listed in table 9 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

<table>
<thead>
<tr>
<th>Audit</th>
<th>Participation</th>
<th>Cases submitted</th>
<th>% Cases required</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Audits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Audit of Schizophrenia</td>
<td>Yes</td>
<td>100/100 audit of practice</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>38/50 service user questionnaires</td>
<td>76%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>17/25 carer questionnaires</td>
<td>68%</td>
</tr>
<tr>
<td>National Audit of Psychological Therapies for Anxiety and Depression</td>
<td>Yes</td>
<td>98 therapist questionnaires</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2039/6 (guideline) case note audits</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>397 service user questionnaires</td>
<td>N/A</td>
</tr>
<tr>
<td>National Audit of Intermediate Care</td>
<td>Yes</td>
<td>3/3 (100%) clinical areas</td>
<td>100%</td>
</tr>
<tr>
<td>POMH-UK</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing ADHD</td>
<td>Yes</td>
<td>284</td>
<td>100% of caseload or representative</td>
</tr>
<tr>
<td>Monitoring of Patients prescribed Lithium</td>
<td>Yes</td>
<td>20</td>
<td>100% of caseload or representative</td>
</tr>
<tr>
<td>Prescribing Anti-Dementia Drugs</td>
<td>Yes</td>
<td>400</td>
<td>100% of caseload or representative</td>
</tr>
</tbody>
</table>

The reports of three national clinical audits were reviewed by the provider in 2013/14. The results of the National Audit of Schizophrenia, Prescribing for ADHD and Prescribing Anti-Dementia Drugs are expected in quarter 1 2014/15. Rotherham Doncaster and South Humber NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

National Audit of Psychological Therapies for Anxiety and Depression:
• Improve data recording
• Improve training and identify future training needs
• Improve accessibility for patients who are 65+
• Ensure staff have access to appropriate supervision

National Audit of Intermediate Care:
• Patients are being engaged in service change i.e. Enhancing the Healing Environment bid for Hawthorn
• The Trust is fully engaged in the Intermediate Care Review Plan, working closely with commissioners
• Service specific training is being undertaken
• All staff now record on a single electronic patient system and a single multi-professional assessment tool is being developed.
Monitoring of Patients prescribed Lithium

- Business division action plans are being presented to the Medicines Management Committee and progress will be monitored by the Clinical Audit Department.

Over 2013/14, 52 Clinical Audits have been completed. The audits conducted across the year have identified the following areas of good practice and areas for improvement:

- **Good practice:**
  - Management of people with a learning disability and mental illness
  - Physical Assessments on admission
  - Care Programme Approach
  - Recovery and Discharge
  - Monitoring of Patients on Lithium
  - Review of Health Assessments for Looked After Children
  - Clinical Supervision

- **Areas for improvement:**
  - Record Keeping
  - Pressure Ulcer management
  - Supervision Training

23. Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Rotherham Doncaster and South Humber NHS Foundation Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 271 at the end of March 2014, against a target of 132. The Trust undertook a significant amount of work to improve the Trust's standing with research, which is now beginning to come to fruition.

24. Commissioning for Quality and Innovation (CQUIN) Scheme 2013/14

A proportion, 2.5% of the annual income equivalent to £3,258,592, of Rotherham Doncaster and South Humber NHS Foundation Trust income in 2013/14 was conditional upon achieving quality improvement and innovation goals agreed between Rotherham Doncaster and South Humber NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. The proportion and amount of the Trusts annual income remains the same as 2012/13. Further details of the agreed goals for 2013/14 are available online at: http://www.england.nhs.uk/wp-content/uploads/2013/02/cquin-guidance.pdf

The Trust achieved 97.9% of the CQUIN indicators and received income of £3,189,570 for 2013/14.
Tables 10-14 show the outcomes of the 2013/14 CQUIN schemes for Community, Mental Health and Learning Disability and Forensic services.

### Table 10 National CQUIN Indicator Framework for 2013/14

<table>
<thead>
<tr>
<th>NHS Safety Thermometer (national indicator)</th>
<th>Partially achieved</th>
</tr>
</thead>
</table>

During 2013/14 the Trust gathered monthly patient safety information from inpatient and community areas. The information included the percentage of:

- Patients who had a pressure ulcer
- Patients who had recently fallen
- Patients who had been treated for a urinary tract infection who had a catheter
- Patients who had harm free care

The indicator concentrated on collecting data in 2013/14. In 2014/15 the indicators focusses on making improvements in each of the four areas above.

### Table 11 Trustwide CQUIN Indicator Framework for 2013/14

<table>
<thead>
<tr>
<th>Patient Experience – including family and friends test</th>
<th>Achieved</th>
</tr>
</thead>
</table>

Partially achieved

- The Trust undertook two surveys of patients and on an agreed date in 2013/14.
- The carer survey was available throughout the year.
- A total of 3318 patient surveys were received, compared to 3241 in 2012/13
- A total of 1155 carer surveys were received, compared to 627 in 2012/13.
- Overall the satisfaction levels of patients and carers were high.
- Examples of where satisfaction levels need improvement for patients include:
  - Ward activities
  - Meals and refreshments
  - Care planning and involvement
- Examples of where satisfaction levels need improvement for carers include:
  - Availability and quality of information
  - Being able to give feedback
- Examples of changes made following feedback from patients and carers includes:
  - Business divisions quality marker schemes have focussed on improving the quality of information provided to patients and carers, and current leaflets are being revised and going through the ‘Get it Write’ panel.
  - The new Trust website to be launched in June 2014 will include an electronic version of the ‘Your Opinion Counts’ form for stakeholders to submit comments.
  - All business divisions have had a ‘Ward hostess’ on inpatient wards, with facilities staff supporting patients in their choice of meals and working with nursing staff to ensure that special diets and portion control requirements are met.
Table 12 Community Services CQUIN Indicator Framework for 2013/14

<table>
<thead>
<tr>
<th>• Community Information and Data</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>During 2013/14 the DCIS business division has focussed on improving the collection of community information and data. Examples of data items collected include:</td>
<td></td>
</tr>
<tr>
<td>• Referral source</td>
<td></td>
</tr>
<tr>
<td>• Discharge destination</td>
<td></td>
</tr>
<tr>
<td>• Diagnosis</td>
<td></td>
</tr>
<tr>
<td>• Use of technology i.e. Telehealth</td>
<td></td>
</tr>
<tr>
<td>Using the improved information and data, the Trust will work with commissioners on improving care pathways.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>• One Team Working</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>The evaluation framework developed as part of the CQUIN in 2012/13 has been used in 2013/14. Feedback collected during the evaluation on One Team Working includes:</td>
<td></td>
</tr>
<tr>
<td>• “Certainly we are doing a lot more joined-up visits which I feel is most definitely a benefit for the patients.”</td>
<td></td>
</tr>
<tr>
<td>• “When we have the MDT we arrange any joint visits that need doing after that and it’s the same thing.”</td>
<td></td>
</tr>
<tr>
<td>• “The administration part has perhaps proved a bit more difficult …we still aren’t quite up to them being able to operate each other’s systems.”</td>
<td></td>
</tr>
</tbody>
</table>

Ben Parkinson opening Hawthorne Ward at Tickhill Road Hospital, Doncaster
Table 13 Mental Health and Learning Disability Services CQUIN indicator framework for 2013/14

<table>
<thead>
<tr>
<th>Category</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transition Planning</strong></td>
<td>In 2012/13 the CQUIN indicator focussed on transitions between the CAMHS and Adult Mental Health services. In 2013/14 the CQUIN indicator was extended to focus on:</td>
</tr>
<tr>
<td></td>
<td>• Transitions between CAMHS to Adult Mental Health services and Learning Disability</td>
</tr>
<tr>
<td></td>
<td>• Patients being jointly worked between Learning Disability and another business division</td>
</tr>
<tr>
<td></td>
<td>• Older Peoples Mental Health S117 discharges to external provision</td>
</tr>
<tr>
<td></td>
<td>Each transition under the categories above was audited twice during 2013/14, against a set of standards agreed with commissioners. All standards were fully achieved at the second audit. Examples of the areas audited include:</td>
</tr>
<tr>
<td></td>
<td>• Patients having an identified care coordinator/named worker</td>
</tr>
<tr>
<td></td>
<td>• Patients having a care plan that outlines the transition arrangements</td>
</tr>
<tr>
<td></td>
<td>• Evidence of joint meetings taking place</td>
</tr>
<tr>
<td></td>
<td>• Evidence of information about the services being shared with the patient</td>
</tr>
<tr>
<td></td>
<td>A further area focussed on as part of the CQUIN indicator is:</td>
</tr>
<tr>
<td></td>
<td>• Transitions between IAPT to Adult Mental Health services</td>
</tr>
<tr>
<td></td>
<td>This element of the CQUIN indicator continues as a piece of work with commissioners in 2014/15 to improve the transition protocol and the patient experience of transition to Adult Mental Health services.</td>
</tr>
<tr>
<td><strong>Recovery, discharge and Planning</strong></td>
<td>Each of the business divisions has identified a recovery outcomes tool for use with their patients. Examples of the tools identified are:</td>
</tr>
<tr>
<td></td>
<td>• Four Factor Model – Adult Mental Health and Older Peoples Mental Health</td>
</tr>
<tr>
<td></td>
<td>• Recovery STAR – Adult Mental Health</td>
</tr>
<tr>
<td></td>
<td>• Health Equalities Framework – Learning Disability</td>
</tr>
<tr>
<td></td>
<td>In 2013/14 the CQUIN indicator has focussed on business divisions implementing the recovery outcome tools and collecting data. In 2014/15 the focus of the CQUIN indicator is being extended to show the outcomes being experienced by patients.</td>
</tr>
</tbody>
</table>
Table 14 Forensic Services CQUIN indicator framework for 2013/14 (Outcomes of the CQUIN indicators has not yet been confirmed by commissioner)

<table>
<thead>
<tr>
<th>Optimising Pathways</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Forensic service has been measured on a number of key areas that indicate whether the pathways are being optimised. Areas include:</td>
<td></td>
</tr>
<tr>
<td>- Referral to acceptance</td>
<td></td>
</tr>
<tr>
<td>- Acceptance to admission</td>
<td></td>
</tr>
<tr>
<td>- Estimated treatment length</td>
<td></td>
</tr>
<tr>
<td>- Average length of stay</td>
<td></td>
</tr>
<tr>
<td>The majority of areas have shown improvement over 2013/14.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provision of literacy, numeracy, IT and vocational skills training</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>During quarter 2 2013/14 feedback was gathered from the patients on Amber Lodge, which suggested that the majority would like to improve their knowledge and skills. Taking into account known cognitive and learning difficulties, a non-standardised, learning disability friendly, assessment tool of basic computer skills was devised by the lead occupational therapist. 75% of the patients on Amber Lodge have undertaken 1:1 assessments of their basic computer skills.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Improving the Care Programme Approach (CPA) process</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>An audit of CPA meetings during 2013/14 showed that:</td>
<td></td>
</tr>
<tr>
<td>- The attendance of care coordinators at the CPA meeting had increased to 71%</td>
<td></td>
</tr>
<tr>
<td>- The attendance of psychology representatives had increased to 88%</td>
<td></td>
</tr>
<tr>
<td>- Nursing staff were in attendance 79% of the time</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Increase in use of communications technology</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amber Lodge has introduced the use of e-meetings. E-meetings will initially be used for:</td>
<td></td>
</tr>
<tr>
<td>- CPA meetings</td>
<td></td>
</tr>
<tr>
<td>- MDT meetings</td>
<td></td>
</tr>
<tr>
<td>The introduction of e-meetings allows family / carers to be involved in the patients meeting.</td>
<td></td>
</tr>
</tbody>
</table>
25. Care Quality Commission (CQC)

Rotherham Doncaster and South Humber NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered with no conditions.

The Care Quality Commission has not taken enforcement action against Rotherham Doncaster and South Humber NHS Foundation Trust during 2013/14.

Rotherham Doncaster and South Humber NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Over 2013/14, the Trust has had a total of 12 inspections to the following Business Divisions:

<table>
<thead>
<tr>
<th>Business Division</th>
<th>Number of visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>DCIS</td>
<td>1</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>10</td>
</tr>
<tr>
<td>Trust Inspection</td>
<td>1</td>
</tr>
</tbody>
</table>

The CQC inspections have taken place in:

**Trust wide**
- Trust Headquarters (reviewing child and adolescent, adult and older people’s inpatient and community mental health services, learning disability inpatient and community services and forensic services)

**Learning Disabilities Business Division**
- 10a/b Station Road, Doncaster
- Danescourt, Doncaster
- 88 Travis Gardens, Doncaster
- Rhymers Court, Rotherham

**Doncaster Community Integrated Services (DCIS)**
- St John’s Hospice, Doncaster

**Learning Disabilities Business Division (provided by South Yorkshire Housing Association Limited)**
- Howbeck Close, Doncaster
- Gardens Lane, Doncaster
- John Street, Rotherham
- 263 Sandringham Road, Doncaster
- Larch Avenue, Doncaster
- Cranworth Close, Rotherham

The Trust has been assessed as **compliant** with the essential standards of quality and safety reviewed by the CQC in the inspections above.

Over 2013/14, the Trust has had a total of 21 CQC Mental Health Act monitoring visits to the following business divisions and services:

<table>
<thead>
<tr>
<th>Business Division</th>
<th>Number of visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Mental Health</td>
<td>8</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>2</td>
</tr>
<tr>
<td>Forensic</td>
<td>3</td>
</tr>
<tr>
<td>Older Peoples Mental Health</td>
<td>6</td>
</tr>
<tr>
<td>Assessment and Application for Detention and Admission</td>
<td>1</td>
</tr>
<tr>
<td>Seclusion Facilities</td>
<td>1</td>
</tr>
</tbody>
</table>
The CQC Mental Health Act monitoring visits, which have all focussed on ‘Domain 2 – Detention in Hospital’, have taken place in:

**Forensic Business Division**
- Jubilee Close, Doncaster
- Amber Lodge, Doncaster

**Adult Mental Health Business Division**
- Skelbrooke Ward, Doncaster
- Osprey Ward, Rotherham
- Cusworth Ward, Doncaster
- Goldcrest Ward, Rotherham
- Coral Lodge, Doncaster
- Brodsworth Ward, Doncaster
- Sandpiper Ward, Rotherham
- Emerald Lodge, Doncaster
- Kingfisher Ward, Rotherham

**Older People’s Mental Health Business Division**
- Coniston Lodge, Doncaster
- Windermere Lodge, Doncaster
- The Glade, Rotherham
- Laurel Ward, North Lincolnshire
- The Brambles, Rotherham

**Learning Disabilities Business Division**
- Rhymer’s Court, Rotherham
- Sapphire Lodge, Doncaster

**Seclusion Facilities**
- Adult Mental Health, Forensic and Learning Disability, Doncaster

The feedback following both the CQC and CQC Mental Health Act inspections has been positive, with no compliance actions after the CQC inspections, and shows a continuing improving picture across the Trust. However there are some themes in the areas of improvement:

- Personalised care
- Record keeping

26. Data quality
Rotherham Doncaster and South Humber NHS Foundation Trust did not submit records during 2013/14 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

27. Information governance
Rotherham Doncaster and South Humber NHS Foundation Trust Information Governance Assessment Report overall score for 2013/14 was 68% overall for the 45 standards, which attained a level 2 in 2013/14 and was graded ‘Satisfactory’.

28. Clinical coding error rate
Rotherham Doncaster and South Humber NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission (it is only appropriate for Acute Secondary Care services).

29. Improving data quality
In April / May 2014, External Audit tested the accuracy of the data and the systems used to monitor the following indicators:

- 100% enhanced Care Programme Approach patients receiving follow-up contact within seven days of discharge from hospital (mandatory indicator)
• Admissions to inpatient services had access to crisis resolution home treatment teams (mandatory indicator)

• Minimising delayed transfers of care (local indicator selected by Council of Governors)

Following the receipt of the External Audit report in May 2014, Rotherham Doncaster and South Humber NHS Foundation Trust will be taking the following actions to improve data quality:

100% enhanced Care Programme Approach patients receiving follow-up contact within seven days of discharge from hospital

Recommendation - A number of patients who are discharged to various places have been incorrectly excluded from the indicator. This includes care homes, non NHS psychiatric wards, non psychiatric wards and prison/custody.

Action – The Trust is amending reporting processes to include those patients who are discharged to non NHS care providers and working with clinical teams to provide a follow up.

Admissions to inpatient services had access to crisis resolution home treatment teams

Recommendation – A ward was omitted from the reported results due to an issue with the configuration of the report used to generate the result.

Action – The Trust has included the ward in the configuration of the report for 2014/15.

Recommendation - Community Treatment Orders (CTO) are correctly exempt from being included in the indicator. The testing identified a number of these patients who had however been re-admitted outside of the CTO process and should be included in the indicator.

Action – The Trust is checking a patient’s status on readmission and ensuring that this is accurately recorded.

Recommendation – Rehab wards have been excluded from the indicator results. This represents a ‘local interpretation’ and such should be disclosed within the Quality Report.

Action – Disclosed as part of indicator construction under table 16.

Minimising delayed transfers of care

Recommendation – A 28 day grace period before a delay is measured has been identified for Older Peoples wards.

Action – The 28 day grace period for Older Peoples wards was removed from the end of quarter 3 2013/14. This change was indicated on the quarter 4 2013/14 submission to Monitor and is now in place for future reporting.

Recommendation – Non acute and HICU beds have been excluded from the indicator calculation incorrectly.

Action – The non acute and HICU beds will be included in the calculation of this indicator in 2014/15.

Recommendation – The process for calculating delays is highly manual and is highlighted as a control weakness.

Action - The Trust agreed a two phase programme of work with 360 Assurance. Phase 1 actions on manual recording were completed by the end of March 2014. Phase 2 actions, including the implementation of an electronic reporting system, will be completed by the end of March 2015.
30. Data quality indicators

From 2012/13 all trusts are required to report against a core set of indicators, for at least the last two reporting periods, using a standardised statement set out in the NHS (Quality Accounts) Amendment Regulations 2012. Trusts are only required to include indicators that are relevant to the services that they provide. The indicators relevant to RDaSH are included in tables 15-20.

Rotherham Doncaster and South Humber NHS Foundation Trust considers that this data is as described for the following reasons:

+ The reported data for this indicator continues to be validated following submission to the Information Centre and therefore varies from that published by the Information Centre.

++This indicator was subject to data testing by PwC, the external auditor, who have recalculated the results. The PwC audited results are reported in the final row of the table. These differences are not material and do not result in a breach of the indicator target. However the Trust has chosen to adjust for the results reported following audit.

Rotherham Doncaster and South Humber NHS Foundation Trust continues to take the following actions to improve this performance and so the quality of its services, by continuing to alert staff that the seven day follow-up is due and providing refresher training for staff as required. The data quality of this indicator has been audited by our external auditors and the outcomes included in section 28.

The indicator is expressed as the proportion of those patients on Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days:

- ‘Patients discharged’ includes patients discharged to their place of residence, care home, residential accommodation, or to non psychiatric care, or to prison;
- The indicator excludes patients who die within seven days of discharge;
- The indicator excludes patients removed from the country as a result of legal precedence within seven days of discharge;
- The indicator excludes patients transferred to NHS psychiatric inpatient ward when discharged from inpatient care;
- The indicator excludes CAMHS (children and adolescent mental health services), i.e. patients aged under 18;
- Those that are recorded as followed up receive face to face contact or a telephone conversation (not text or phone messages); and
- The seven day period should be measured in days not hours and should start on the day after discharge.

<table>
<thead>
<tr>
<th>Table 15: % of patients on CPA who were followed up within seven days after discharge from psychiatric in-patient care during the reporting period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
</tr>
<tr>
<td>------------</td>
</tr>
<tr>
<td>2013/14 All England Average</td>
</tr>
<tr>
<td>Source: Information Centre Portal</td>
</tr>
<tr>
<td>2013/14 RDaSH</td>
</tr>
<tr>
<td>Source: Information Centre Portal</td>
</tr>
<tr>
<td>2012/13 RDaSH</td>
</tr>
<tr>
<td>Source: Information Centre Portal</td>
</tr>
<tr>
<td>2013/14 RDaSH reported +</td>
</tr>
<tr>
<td>2013/14 RDaSH adjusted++</td>
</tr>
</tbody>
</table>
This indicator was subject to data testing by PwC, the external auditor, who have recalculated the results. The PwC audited results are reported in the final row of the table. These differences are not material and do not result in a breach of the indicator target. However, the Trust has chosen to adjust for the results reported following audit.

Rotherham Doncaster and South Humber NHS Foundation Trust considers that this data is as described for the following reasons:

- During 2013/14, the trust monitored all admission to acute wards to ensure that the Crisis Resolution Home Treatment Team acted as gatekeeper for all appropriate patients. The threshold set by Monitor is 95%, which the Trust has achieved.

Rotherham Doncaster and South Humber NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by implementing an electronic tool in all Access Teams, which is being used consistently and has resulted in a significant improvement in the accuracy of data. The data quality of this indicator has been audited by our external auditors and the outcomes included in section 28.

The indicator is expressed as proportion of inpatient admissions gatekept by the crisis resolution home treatment teams in the year ended 31 March 2014:

- The indicator should be expressed as a percentage of all admissions to psychiatric inpatient wards;
- Patients recalled on Community Treatment Order should be excluded from the indicator;
- Patients transferred from another NHS hospital for psychiatric treatment should be excluded from the indicator;
- Internal transfers of service users between wards in the trust for psychiatry treatment should be excluded from the indicator;
- Patients on leave under Section 17 of the Mental Health Act should be excluded from the indicator;
- Planned admission for psychiatric care from specialist units such as eating disorder unit are excluded;
- An admission should be reported as gatekept by a crisis resolution team where they have assessed* the service user before admission and if the crisis resolution team were involved in the decision-making process which resulted in an admission;
  *An assessment should be recorded if there is direct contact between a member of the team and the referred patient, irrespective of the setting, and an assessment made. The assessment may be made via a phone conversation or by any face-to-face contact with the patient;
- Where the admission is from out of the trust area and where the patient was seen by the local crisis team (out of area) and only admitted to this trust because they had no available beds in the local areas,
the admission should only be recorded as gatekept if the CR team assure themselves that gatekeeping was carried out;

• The Trust has excluded those wards designated as rehab wards from the calculation, as these are classified as planned transfers.

Table 17 % patients re-admitted to hospital within 28 days of being discharged.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2011/12 RDaSH</th>
<th>All England Average 2011/12</th>
<th>2010/11 RDaSH</th>
</tr>
</thead>
<tbody>
<tr>
<td>% patients re-admitted to hospital within 28 days of being discharged aged 0-14</td>
<td>No data available</td>
<td>No data available</td>
<td>No data available</td>
</tr>
<tr>
<td>% patients re-admitted to hospital within 28 days of being discharged aged 0-14</td>
<td>13.51%</td>
<td>11.45%</td>
<td>No data available</td>
</tr>
</tbody>
</table>

Source: Information Centre Portal

Rotherham Doncaster and South Humber NHS Foundation Trust considers that this data is as described for the following reasons:

• The Trust does monitor the % of patients who are re-admitted to any of its acute mental health wards within 30 days as a locally commissioned target. All re-admissions are investigated and reported within the Trust and to commissioners.

RDaSH has taken the following action to improve this performance, and so the quality of its services, by analysing and taking action from the common themes from investigating the reasons for re-admission with the aim of reducing re-admissions in future.

Table 18 % Staff Employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family of friends

<table>
<thead>
<tr>
<th>Staff Survey Questions</th>
<th>2012 RDaSH % strongly agree or agree</th>
<th>2013 RDaSH % strongly agree or agree</th>
<th>2013 average for other mental health trusts % strongly agree or agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust</td>
<td>63%</td>
<td>63%</td>
<td>59%</td>
</tr>
</tbody>
</table>

Source: Information Centre Portal
Rotherham Doncaster and South Humber NHS Foundation Trust considers that this data is as described for the following reasons:

- As part of the CQC Staff Survey, mental health, learning disability and community staff are asked the question ‘If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust’. The Trust has performed above the national average in this area.

RDaSH has taken the following action to improve this performance and so the quality of its services, by all services developing and implementing action plans following the publication of the results of the CQC Staff Survey. These action plans are monitored and reported to the Human Resources and Organisational Development Group, one of the four policy and planning groups reporting to the Board of Directors.

Rotherham Doncaster and South Humber NHS Foundation Trust considers that this data is as described for the following reasons:

- the RDaSH score against the indicator has remained consistent over the past three years and above the England score in all three years.

<table>
<thead>
<tr>
<th>Table 19 % Patient experience of community mental health services – patient experience of contact with a health or social care worker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust 2013 Score</td>
</tr>
<tr>
<td>88.5</td>
</tr>
</tbody>
</table>

Source: Information Centre Portal

Rotherham Doncaster and South Humber NHS Foundation Trust considers that this data is as described for the following reasons:

<table>
<thead>
<tr>
<th>Table 20 % Number and rate of Patient Safety Incidents reported within the Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Safety Incidents (PSI)</td>
</tr>
<tr>
<td>Total number of deaths</td>
</tr>
<tr>
<td>Total number of severe patient safety incidents</td>
</tr>
<tr>
<td>% of PSI resulting in death</td>
</tr>
<tr>
<td>% of PSI resulting in severe harm</td>
</tr>
</tbody>
</table>

Source: Information Centre Portal

RDaSH has taken the following action to improve this score, and so the quality of its services, by the Adult Mental Health and Older Peoples Mental Health business divisions developing and implementing an action plan to improve scores. Progress against the action plan is reported to the Clinical Effectiveness Committee.

Rotherham Doncaster and South Humber NHS Foundation Trust considers that this data is as described for the following reasons:

- the total number of deaths and severe patient safety incidents has reduced in comparison to the 2012 data. The number of PSI resulting in death and severe harm remains consistent with the national average for mental health trusts.

Rotherham Doncaster and South Humber NHS Foundation Trust has taken the following actions to improve this rate/number, and so the quality of its services, by undertaking additional reporting via the Organisational Learning Forum, of analysing the Monitor categories of ‘Severe Harm’ and ‘Death’ of patient safety incidents. All serious incidents continue to be investigated with reports and action plans agreed and followed up with commissioners.
RDaSH reports its quality improvement work to stakeholders through the three nationally recognised domains of quality:

- Patient safety
- Clinical effectiveness
- Patient experience

In addition, the Trust also reports in the domain of:

- Our people/staff

The indicators reported in each of the four domains are key indicators reported nationally and are included within our contracts with commissioners.

**Patient safety**

**31. Learning from patient safety incidents**

**31.1 Never events**

During 2013/14, RDaSH has had:

0 never events (never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented)

**31.2 Serious incidents**

In 2013/14, RDaSH reported 99 serious incidents. Table 21 shows the number of serious incidents in comparison to the past three years.

<table>
<thead>
<tr>
<th>Table 21 Number of serious incidents reported</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Number</td>
</tr>
<tr>
<td>2013/14</td>
</tr>
<tr>
<td>Number</td>
</tr>
</tbody>
</table>

*Reporting of Grade 3 Pressure Ulcers as an SI began on 21 October 2013. The Trust reported 86 SIs in 2013/14 if Grade 3 Pressure Ulcers are excluded from the total.

Source: Strategic Executive Reporting System (STEIS)

NB. The size of the Trust’s portfolio of services increased significantly in 2010/11 under the Transforming Community Services initiative.

The main categories of serious incidents reported in 2013/14 were:

- Suicide
- Unexpected Death
- Pressure Ulcers
- Slips/trips/falls
31.3 Patient safety incidents

The Trust reports patient safety incidents to the NHS Commissioning Board National Reporting and Learning Service (NRLS). The NRLS provides six monthly reports to the Trust which contains comparative information on our reporting rate per 1,000 bed days, types of incidents reported and incidents reported by degree of harm, compared with 56 similar organisations.

The majority of patient safety incidents reported by the Trust fall into the following categories:

- Violence, Abuse or Harassment
- Adverse Healthcare Event
- Patient Accident/Incident

Table 22 shows the number and rate of PSI against the categories of Severe and Death.

<table>
<thead>
<tr>
<th>Patient Safety Incidents (PSI)</th>
<th>(1) 1 April – 30 September 2013 RDaSH NRLS Data</th>
<th>(2) 1 April – 30 September 2013 All MH Trusts NRLS Data</th>
<th>(3) 1 April – 30 September 2012 RDaSH NRLS Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of deaths</td>
<td>24</td>
<td>1106</td>
<td>30</td>
</tr>
<tr>
<td>Total number of severe patient safety incidents</td>
<td>11</td>
<td>442</td>
<td>14</td>
</tr>
<tr>
<td>% of PSI resulting in death</td>
<td>0.9%</td>
<td>0.9%</td>
<td>1.0%</td>
</tr>
<tr>
<td>% of PSI resulting in severe harm</td>
<td>0.4%</td>
<td>0.4%</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

Source: Information Centre Portal

31.4 Key areas for improvement identified from incidents

Care planning, records and communication remain some of the most frequently occurring themes. Over 50% of serious incidents take place within the Adult Mental Health business division (AMH) and the majority of the remainder are spread between Doncaster Community Integrated Services (DCIS), Older People’s and Drug and Alcohol Services business divisions.

Our analysis has identified the following key areas for improvement:

- Joint communication and care planning by teams
- Involvement of, and communication with carers
- Service information to patients’ carers, prior to admission
- Timely implementation and evaluation of care
- Clinical risk management
- Safe transport of patients and service users
- Leave and discharge planning
- Care transfer between in-patient and community services
- Record keeping

The Trust’s Patient Safety Team monitor performance against the serious incidents action plans monthly. In addition, the Clinical Governance Group tasked the Organisational Learning Forum to review the Adult Mental Health and Doncaster Community Integrated Services action plans to ensure that the plans were robust, actions implemented and improvements made.
31.5 Organisational learning

The Trust’s Organisational Learning Forum (OLF) brings clinical staff together from each of the Trust’s business divisions to share themes and learning from incidents, complaints and claims. It provides an opportunity for challenge and robust discussion regarding incident reporting, actions taken and learning. Members of OLF are responsible for the further dissemination and discussion of this information within their services.

Examples of Trust wide improvements made during 2013/14 as a result of shared learning from incidents include:

- Trust Patient Safety Lead has worked with business divisions to look at ligature points and other environmental issues and considered options available in conjunction with Estates Department and Head of Health, Safety and Security.
- A Standard Operating Procedure (SOP) for managing communication from the Coroner’s office has been written.
- The Board Secretary has sourced and provided to services a list of telephone numbers from the Trust’s solicitors for out of hours legal advice on the Mental Capacity Act 2005.
- A Practice Development Day was held in the Adult Mental Health business division for both inpatient and community services, looking at carers’ needs and information governance in relation to carers.

32. Safeguarding

NHS Trusts are required to make a self-declaration identifying compliance against their arrangements with regard to Safeguarding Children and Safeguarding Vulnerable Adults.

RDaSH continues to be compliant against all of the standards relating to provider trusts. Details of the full declaration submitted by RDaSH are available on the Trust website (http://www.rdash.nhs.uk/information-for-the-public/safeguarding/).

The Trust has published Safeguarding Children and Safeguarding Vulnerable Adults annual reports, which are available on the Trust website. The Trust is currently producing the Safeguarding Vulnerable Adults, Safeguarding Children and Looked After Children Annual Report which will provide detail on the progress made in these areas over 2013/14.

32.1 Safeguarding Children and Vulnerable Adults

As a trust we are committed to ensuring that all our staff across all the business divisions remain vigilant and are aware of the issues relating to Safeguarding Children and Vulnerable Adults.

RDaSH works very closely with the five Local Safeguarding Children and Vulnerable Adults Boards (LSCBs/LSAPBs) across the geographical areas it covers, and has representatives on the Boards in the three main Trust service localities of Doncaster, Rotherham and North Lincolnshire.

- **Section 11 Audit**

  Throughout 2013/14 the RDaSH Safeguarding Children Team has continued to make progress against the new Section 11 documentation. Doncaster’s Section 11 documentation has been updated and discussions have taken place as to how best to obtain the views and experiences of children, young people and families around safeguarding issues. The same process is now being undertaken in North Lincolnshire and Rotherham.

- **Training**

  RDaSH has an up to date safeguarding children and safeguarding vulnerable adults training strategy and training programme available to all staff, and multi-disciplinary training continues to be delivered across the Trust at all levels. Training compliance is shown in table 23:

<table>
<thead>
<tr>
<th>Table 23 Safeguarding Training Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2013/14</strong></td>
</tr>
<tr>
<td>Safeguarding Children</td>
</tr>
<tr>
<td>Safeguarding Adults</td>
</tr>
</tbody>
</table>

Source: Oracle Learning Management System
32.2  Looked After Children (LAC) Doncaster

We are continuing to work in close partnership with our health and social care colleagues to develop a pathway of care for all looked after children and young people in Doncaster from the time they enter the care system, until they leave care.

Each LAC/Young Person receives an Initial and Review Health Assessment (6 monthly for the 0 - 4 age group and yearly for the 5-18 age group) resulting in a personal health plan that is monitored and reviewed according to each child's needs.

The co-ordination and monitoring of the pathway will continue to be provided by the Trust LAC Health Team.

33.  Infection prevention and control

Infection prevention and control (IPC) is the term used to ensure that the Trust's services have the lowest number of infections possible; this is very important to the Trust. Infection rates are very low and have been since information was collected. This has continued in 2013/14 as shown in table 24. RDaSH is very proud of its infection control rates and continues to review and monitor how its infection control services have performed.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2013/14</th>
<th>2012/13</th>
<th>2011/12</th>
<th>2010/11</th>
</tr>
</thead>
<tbody>
<tr>
<td>E.Coli Bacteraemia</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MRSA</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>C-Diff</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: Local Reporting System, cases as defined by Health Protection Agency Guidelines

Clinical Effectiveness

The Trust has reviewed its performance on clinical effectiveness using a number of key measures and indicators. Staff training and clinical supervision are key to helping deliver effective clinical practice and table 25 demonstrates how many staff believe that the training they have received has helped them to keep up to date with professional requirement.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2013 (%)</th>
<th>2012 (%)</th>
<th>2011 (%)</th>
<th>2010 (%)</th>
<th>All Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly disagree</td>
<td>7</td>
<td>6</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Disagree</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Neither agree or disagree</td>
<td>17</td>
<td>16</td>
<td>23</td>
<td>23</td>
<td>14</td>
</tr>
<tr>
<td>Agree</td>
<td>53</td>
<td>53</td>
<td>53</td>
<td>54</td>
<td>53</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>21</td>
<td>22</td>
<td>14</td>
<td>12</td>
<td>22</td>
</tr>
</tbody>
</table>

Source: Staff Survey, National Survey
Other indicators of clinical effectiveness are reported through the Monitor risk assessment framework and include:

- Care programme approach: Follow-up contact within 7 days of discharge
- Care programme approach: Having formal review within 12 months
- Minimising delayed transfers of care
- Admissions to inpatients services has access to Crisis Resolution/Home Treatment teams
- Meeting commitment to service new psychosis cases by early intervention

Performance against these indicators is reported in table 32 in comparison to the previous two years.

34. National Institute for Health and Clinical Excellence (NICE)

NICE guidance supports healthcare professionals and others to make sure that the care they provide is of the best possible quality and offers the best value for money.

NICE issues guidance monthly and this is circulated widely throughout the Trust and to members of the Clinical Effectiveness Committee. We then decide if the guidance is relevant and at what level, then undertake a gap analysis where required, to identify if our services meet the guidance, to identify any risks and to develop an improvement action plan.

Over 2013/14 NICE has published 129 pieces of guidance, of which 26 have been determined to be relevant to the Trust in some way. The Trust has initiated implementation of 21 pieces of NICE Guidance with plans in place for the remaining 5 which have only recently been issued. Guidance published in 2013/14 includes the following:

- Smoking cessation in acute, maternity and mental health services – applicable Trust-wide and therefore the impact of this guidance is significant. Discussions have been held at the Senior Leadership Team, Clinical Governance Group and Clinical Effectiveness about the next steps with regard to implementation.

34.1 NICE quality standards

NICE quality standards set out what a quality service should achieve.

RDaSH uses NICE quality standards to develop services for our patients and make sure they deliver the best care possible.

We have developed a system to ensure that as NICE quality standards are published, we ensure that our services are delivered in this way. Following a successful pilot, a template of this system is now available for all business divisions to use when reporting on quality standards.

Examples of quality standards published in 2013/14 with some relevance to the Trust are:

- Supporting people to live well with dementia
- Health and wellbeing of looked-after children and young people
- Lower urinary tract symptoms

34.2 NICE consultations

The Trust has continued to register as a stakeholder with NICE throughout the year, so that we can proactively contribute to consultations on the development of guidance and quality standards.

In 2013/14 the Trust has contributed as a stakeholder with NICE to the following consultations and has agreed to be identified as consultation contributors:

- Constipation in children and young people
- Infection Control
- Delirium
- Autism in Children and Young People
- Conduct Disorders
- Mental wellbeing of older people in residential care
- Challenging Behaviour Learning Disability
Patient Experience

The Trust uses different methods to obtain feedback and information from patients, service users and carers within the overall framework of its ‘Patient, Carer and Public Engagement and Experience Strategy’. Tables 26-29 show performance against key measures and indicators over the previous three years. Methods of obtaining patient experience feedback include:

- Patient / carer groups;
- Complaints;
- Patient Advice and Liaison Service;
- Surveys – national / local;
- Consultation events;
- Compliments;
- ‘Your Opinion Counts’;
- Workshops.

35. Listen to Learn

‘Listen to Learn’, the Trust Patient, Carer and Public Engagement and Experience Strategy was ratified by the BoD in August 2013.

The first two meetings of the Listen to Learn Steering Group were held in November 2013 and January 2014 with over 40 people from a range of backgrounds attending each of the meetings. Representatives attended from patient and carer groups, local Healthwatch, Doncaster CVS, the Council of Governors and each of the seven business divisions, providing a voice for the full range of Trust services.

The ‘Ladder of Participation’ has been introduced to all stakeholders, a method of measuring the level of patient and carer participation in services. The Listen to Learn Steering Groups have focussed on patients and carers ‘getting to know’ services and members participating in interactive exercises, highlighting where each business division currently sits on the Ladder and plans to be taken forward during 2014/15, linking to the business division patient experience quality markers, to increase patient/carer participation in services.

36. National Mental Health Community Survey 2013 results

The Trust participated in this annual survey which reflects the experiences of more than 17,000 people who have used community mental health services in England in the last 12 months.

This was the tenth annual survey (undertaken 2004 to 2013) and provides the Trust with an opportunity to monitor progress over time based on feedback from people about the services they received.

The survey is undertaken, by an independent contractor – Picker Institute Europe, through a postal questionnaire, sent to a random sample of 850 Trust services users, who were seen in the period 1 July 2012 to 30 September 2012.

The Trust response rate was 33% compared to a national average of 29%, showing an increase from last year, when our response rate was 28%.

Table 26 shows that there has been a slight increase in the number of service users rating the care they received from RDaSH in the last 12 months as ‘excellent,’ ‘very good’ or ‘good’ and also a slight increase in the overall satisfaction with the level of involvement of members of family/persons closest to the patient.

<table>
<thead>
<tr>
<th>Table 26 Patient Survey*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
</tr>
<tr>
<td>Overall rating of quality of care received as ‘excellent’, ‘very good’ or ‘good’</td>
</tr>
<tr>
<td>Overall satisfaction with the level of involvement of member of family/ person close to patient</td>
</tr>
</tbody>
</table>

Source: Mental Health Community Surveys, national survey.
37. Listening to service users, patients and carers

In addition to the National Community Mental Health Survey, the Trust listens to service users, patients and carers through:

- Complaints;
- Your Opinion Counts;
- Patient Advice Liaison Service (PALS);
- Patient Opinion.

37.1 Complaints and compliments

Most care and treatment goes well, but things occasionally do go wrong, and RDaSH has a complaints policy to provide a framework to:

- Provide fair and equitable access for patients and service users to make complaints and to provide an honest and open response to these complaints.
- Provide patients and service users and those acting on their behalf with support to bring a complaint or to make a comment, where such assistance is necessary
- Have mechanisms in place to learn from complaints and to share this learning across the Trust where appropriate.

Lessons learned from complaints are shared through the Organisational Learning Forum and outcomes are acted upon within the quality improvement work.

The main categories of complaints received within the Trust relate to:

- Communication/ information to patients/ about patients to relatives
- Attitude of staff
- Concern about aspects of clinical care
- Care plans not being made available to patients

Table 27 shows the number of complaints across the Trust in comparison to the previous three years. There has been an increase in the number of complaints, which will be subject to further analysis and improvement actions during 2014/15. The main themes identified within complaints include staff attitude and communication.

<table>
<thead>
<tr>
<th>Table 27 Complaints and compliments across the Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
</tr>
<tr>
<td>Complaints</td>
</tr>
<tr>
<td>Compliments</td>
</tr>
</tbody>
</table>

Source: Safeguard Incident Reporting System

NB. The size of the Trust's portfolio of services increased significantly in 2010/11 under the Transforming Community Services initiative.

Patients and service users may also want to contribute positive comments on the care and services that they have received. These comments are just as important because they tell us which factors are contributing to a good experience for patients. Table 27 also shows the number of compliments that have been received in 2013/14. The majority of both complaints and compliments have been received by the Adult Mental Health and DCIS business divisions.

Feedback received through the Trust's patient experience office is shared with the relevant business divisions, to both disseminate the positive comments that have been received and to develop action plans to address areas of concern.
A number of ‘You Said, We Did’ posters have been displayed in the public areas of the Trust to demonstrate how services have acted on service user/patient feedback and to encourage further feedback.

37.2 Your Opinion Counts / Patient Advice Liaison Service

‘Your Opinion Counts’ (YOCs) and the Patient Advice Liaison Service (PALS) provide patients, service users and carers with alternative methods of providing feedback to the Trust. Table 28 shows the number of PALS and YOC received in 2013/14.

Source: Safeguard, Trust reporting system and local reporting system

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th>2012/13</th>
<th>2011/12</th>
<th>2010/11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Advice Liaison Service</td>
<td>392</td>
<td>267</td>
<td>370</td>
<td>422</td>
</tr>
<tr>
<td>Your Opinion Counts</td>
<td>3740</td>
<td>2668</td>
<td>2776</td>
<td>355</td>
</tr>
</tbody>
</table>

The feedback received through YOCs continues to be predominantly positive. The types of enquiries received through PALS are:

- General concern
- Information request
- Signposting
- Request for advice

38. Eliminating mixed sex accommodation (EMSA)

Providers of NHS funded care are asked to confirm whether they are compliant with the national definition “to eliminate mixed sex accommodation except where it is the overall best interests of the patient, or reflects their patient choice”. The Trust’s EMSA declaration 2013/14 can be found on (http://www.rdash.nhs.uk/about-us/public-declarations/delivering-same-sex-accommodation/). The Trust has an excellent record in eliminating mixed sex accommodation, with the majority of inpatient care being provided on wards that have single en-suite bedrooms. For those wards that do not have en-suite facilities clear guidance is provided for the care of patients to ensure that no breach occurs and also to maintain all patients privacy and dignity. All mental health and learning disability wards also have female only lounges. Eliminating mixed sex accommodation is only part of the patients experience with regard to maintaining their privacy and dignity and therefore there is an ongoing work programme in place with all inpatient modern matrons. This work continually updates approaches and ensures the Trust maintains the high profile that dignity within care should have. This work is reported into the Trust’s Clinical Effectiveness Committee.

Breaches in providing same sex accommodation

There has been 1 reported breach in EMSA during Quarter 4, 2013/14 in the Learning Disabilities business division; Rhymer’s Court, Rotherham where there was a short period with no access to a female only lounge.

Remedial action was taken immediately and a subsequent Quality Visit undertaken. Rotherham Clinical Commissioning Group has been informed of this breach.
For 2013/14, Patient-Led Assessments of the Care Environment (PLACE) have replaced the previous Patient Environment Action Team (PEAT) assessments conducted at healthcare organisations across the country.

The primary change to the assessment process is the increased presence of patients as part of the visiting team, which now make up a minimum of 50% of the team. The PLACE assessments were undertaken in January 2013. PLACE covers broadly the same areas that were covered by PEAT assessments; namely:

- Privacy, dignity and wellbeing;
- Cleanliness;
- Condition, appearance and maintenance and
- Food and hydration.

Following the assessments within each service, every participating organisation is given a score, expressed as a percentage of the maximum score, for each of the four domains in the assessment. The results for all 274 participating organisations were published on 18 September 2013 and provide a position for the Trust in relation to each of the four domains as well as overall, as follows:

<table>
<thead>
<tr>
<th>Domain</th>
<th>Trust rank</th>
<th>Trust Average</th>
<th>National Average</th>
<th>National Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>123 of 274</td>
<td>90.98%</td>
<td>89.87%</td>
<td>76.54% - 98.24%</td>
</tr>
<tr>
<td>Privacy, dignity and wellbeing</td>
<td>65 of 274</td>
<td>93.12%</td>
<td>88.87%</td>
<td>73.35% - 100.00%</td>
</tr>
<tr>
<td>Cleanliness</td>
<td>91 of 274</td>
<td>98.30%</td>
<td>95.74%</td>
<td>75.94% - 100.00%</td>
</tr>
<tr>
<td>Condition, appearance and maintenance</td>
<td>25 of 274</td>
<td>99.35%</td>
<td>88.75%</td>
<td>71.39% - 99.35%</td>
</tr>
<tr>
<td>Food and hydration</td>
<td>241 of 274</td>
<td>77.17%</td>
<td>84.98%</td>
<td>61.24% - 100.00%</td>
</tr>
</tbody>
</table>

Key

Red: > 5% below national average  Amber: < 5% below national average  Green: above national average

The results show that as an organisation, the Trust has performed best in the domain of ‘condition, appearance and maintenance’ with a score significantly higher than the national average and ranked in the top 10% of participating organisations.

However, the Trust has scored poorly in the domain of ‘food and hydration’ with a score significantly lower than the national average and ranked in the bottom 15% of participating organisations. The RDaSH catering team is currently working on an amended menu book, individually weighing out all menu items to more accurately determine portions. The ‘Ward Hostess’ pilot has been undertaken, with facilities staff supporting patients in their choice of meals and working with nursing staff to ensure that special diets and portion control requirements are met.

The Trust has scored better than average and in the top third of organisations for both ‘cleanliness’ and ‘privacy, dignity and wellbeing’.
40. Staff views of quality

Staff are vital to the delivery of high quality, safe and clinically effective care. The views of our staff on their ability to deliver high quality care are important in helping us shape our plans for quality improvement. Tables 30 and 31 show performance against key measures and indicators over previous years.

The Trust uses different methods to engage with staff and to secure their views, including:

- Surveys
- Leading the Way with Quality workshops
- Chief Executive blog
- Professional networks
- Trust matters
- Board member visits to services

<table>
<thead>
<tr>
<th>Staff Survey Questions</th>
<th>2012 RDaSH</th>
<th>2013 RDaSH</th>
<th>2013 average for other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior managers where I work are committed to patient care</td>
<td>54%</td>
<td>59%</td>
<td>52%</td>
</tr>
<tr>
<td>If a friend or relative needed treatment, I would be happy with the standard of care</td>
<td>63%</td>
<td>63%</td>
<td>59%</td>
</tr>
<tr>
<td>provided by this Trust</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am satisfied with the quality of care I give to patients/service users</td>
<td>72%</td>
<td>66%</td>
<td>70%</td>
</tr>
<tr>
<td>I feel that my role makes a difference to patients/service users</td>
<td>78%</td>
<td>78%</td>
<td>81%</td>
</tr>
<tr>
<td>I am able to deliver the patient care I aspire to</td>
<td>58%</td>
<td>51%</td>
<td>52%</td>
</tr>
<tr>
<td>I am able to make improvements happen in my area of work</td>
<td>57%</td>
<td>55%</td>
<td>60%</td>
</tr>
</tbody>
</table>

40.1 Staff survey

Source: Information Centre Portal

We have received detailed feedback on the 2013 staff survey. Headlines from the Care Quality Commission (CQC) Staff Survey summary report are:

- A total of 59% of the Trust’s staff surveyed completed their 2013 questionnaire, compared to 56% in 2012.
- The Trust has seen an improvement in all of the CQC pledge areas compared to 2012 with the exception of two areas. Namely, a 1% reduction in team members stating they have shared objectives (from 78% in 2012 to 77% in 2013) and the % of staff having an appraisal in the last 12 months has decreased from 81% (2012) to 79% (2013) and we are also below the national average in this area (87%).
• ‘Communication between senior management and staff is effective’ has improved by 6% from 40% in 2012 to 46% in 2013 and exceeds the national average (37%).

• The Trust had improved at 57% (on the 2012 result 54%) relating to ‘my manager asks for my opinion before making decisions which affect me’.

• The Trust had improved in the percentage of staff who ‘believe care of patients/service users was the Trust’s top priority’ with the Trust result being 66% and the national average 64% (the 2012 Trust result was 60%).

• 59% of staff would recommend the Trust as a place to work compared to the national average at 55% (54% in RDaSH 2012 results).

40.2 Staff sickness absence

The Trust’s staff sickness absence rate has decreased in the calendar year in comparison to 2012.

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>5.4%</td>
</tr>
<tr>
<td>2012</td>
<td>5.5%</td>
</tr>
<tr>
<td>2011</td>
<td>5.3%</td>
</tr>
<tr>
<td>2010</td>
<td>5.7%</td>
</tr>
</tbody>
</table>

Data Source: NHS iView

The main reason for sickness absence remains as stress and anxiety, but this is a combination of both work and personal stress and anxiety. The Trust has implemented a number of support programmes for employees (Employee Assistance Programme, Counselling and Stress and Anxiety Classes).

41. Leading the Way with Quality

The focus of the Leading the Way with Quality sessions held in February and March 2014 was ‘Fit for the Future’ and provided an opportunity for staff member in Bands 1-6 and those in bands 7 to 8 who were not on F4F because they do not lead a team to discuss a number of issues building on the F4F leadership programme. There was a chance to discuss the organisation’s strategy and values post Francis, our approach to future staff development and support and how we can develop a nourishing and engaging staff culture within the organisation. Feedback from the LWQ sessions was complimentary, with staff stating that the sessions were informative, enjoyable and interesting.
Performance against key national priorities

42. Monitor Compliance Framework 2013/14

Monitor also set targets for Foundation Trusts as part of its ‘Risk Assessment Framework – 2013/14’. Table 32 shows our progress against the Mental Health and Learning Disability governance indicators for 2013/14 and where applicable includes comparative information for the two previous years.

Table 32 Performance against Monitor’s mental health governance indicators

<table>
<thead>
<tr>
<th>Targets</th>
<th>Threshold</th>
<th>2013/14</th>
<th>2012/13</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Programme Approach:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up contact within seven days of discharge</td>
<td>95%</td>
<td>99.3%</td>
<td>99%</td>
<td>98.5%</td>
</tr>
<tr>
<td>Care Programme Approach:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having formal review within 12 months</td>
<td>95%</td>
<td>98.28%</td>
<td>97.17%</td>
<td>95.76%</td>
</tr>
<tr>
<td>Minimising delayed transfers of care</td>
<td>&lt;= 7.5%</td>
<td>1.8%*</td>
<td>0.9%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Admissions to inpatients services has access to Crisis Resolution/Home Treatment Teams</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
<td>99.5%</td>
</tr>
<tr>
<td>Meeting commitment to service new psychosis cases by early intervention</td>
<td>95%</td>
<td>100%</td>
<td>&gt;100%</td>
<td>&gt;100%</td>
</tr>
<tr>
<td>Data completeness identifiers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- NHS number</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Date of birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Postcode (normal residence)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Current gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Registered general medical practice organisation code</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Commissioner organisation code</td>
<td>97%</td>
<td>99.59%</td>
<td>99.77%</td>
<td>99%</td>
</tr>
<tr>
<td>Data completeness:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcomes for patients on CPA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Settled accommodation</td>
<td>50%</td>
<td>94.88%</td>
<td>94.67%</td>
<td>64.95%</td>
</tr>
<tr>
<td>- employment</td>
<td>50%</td>
<td>94.84%</td>
<td>94.58%</td>
<td>64.91%</td>
</tr>
<tr>
<td>- Having a HoNOS assessment in the last 12 months*</td>
<td>50%</td>
<td>93.65%</td>
<td>95.70%</td>
<td></td>
</tr>
<tr>
<td>Access to healthcare for people with a learning disability</td>
<td>n/a</td>
<td>Compliant</td>
<td>Compliant</td>
<td>Compliant</td>
</tr>
</tbody>
</table>

*Following a recommendation from 360 Assurance, the Trust’s Internal Auditors, from quarter 3, 2013/14 the 28 day grace period for reporting delays was removed from Older People’s Mental Health Services. This has resulted in an increase in the numbers of delay days reported in Q4 and impacted on the overall 2013/14 performance.
Monitor introduced Community Care governance indicators as part of the ‘Compliance Framework – 2011/12’. Table 33 shows our progress against these indicators.

### Table 33 Performance against Monitor’s community care governance indicators

<table>
<thead>
<tr>
<th>Targets</th>
<th>Threshold</th>
<th>2013/14</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral to treatment information</td>
<td>50%</td>
<td>97.97%</td>
<td>98.64</td>
</tr>
<tr>
<td>Referral information</td>
<td>50%</td>
<td>100%</td>
<td>99.91%</td>
</tr>
<tr>
<td>Treatment activity information</td>
<td>50%</td>
<td>96.61%</td>
<td>97.01%</td>
</tr>
</tbody>
</table>

### 43. Monitor Risk Ratings 2013/14

The Trust submits quarterly declarations to Monitor in relation to continuity of services and governance. Monitor reviews the declaration and issues a quarterly risk rating for each element:

- continuity of services rating (rated 1-4, where 1 represents the highest risk and 4 the lowest)
- governance rating (trusts are rated green if no issues are identified and red where we are taking enforcement action)

Tables 34 and 35 show the ratings for the four quarters of 2013/14 and 2012/13 compared with the Trust’s expectations at the beginning of the year, as stated in the Annual Plan.

### Table 34 2013/14 risk rating compared to Annual Plan

<table>
<thead>
<tr>
<th></th>
<th>Annual Plan 2013/14</th>
<th>Quarter 1 2013/14</th>
<th>Quarter 2 2013/14</th>
<th>Quarter 3 2013/14</th>
<th>Quarter 4 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuity of services</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>rating</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
</tr>
</tbody>
</table>

### Table 35 2012/13 risk rating compared to Annual Plan

<table>
<thead>
<tr>
<th></th>
<th>Annual Plan 2012/13</th>
<th>Quarter 1 2012/13</th>
<th>Quarter 2 2012/13</th>
<th>Quarter 3 2012/13</th>
<th>Quarter 4 2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial risk rating</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Governance risk rating</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
</tr>
</tbody>
</table>
Doncaster Clinical Commissioning Group (CCG) is pleased to comment on the Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) annual Quality Report 2013/14 and Forward Strategy 2014/2015. Partnership working with our local Trusts ensures a robust joint approach to the commissioning and delivery of care to patients in Doncaster. We will continue to work together to ensure the best quality and evidence based care is available to all.

The report gives a balanced view of the Trusts successes and challenges during the year. The Forward Strategy acknowledges these challenges and outlines key areas of work and focus for the coming year. Doncaster CCG believes that these will be addressed positively throughout the year to improve care quality and clinical outcomes for patients.

The Trust has demonstrated an open and honest culture. This approach has enabled a shared understanding of some of the key challenges and some significant service reviews to be undertaken collaboratively with the Clinical Commissioning Group. Significant redesign of the Community Nursing Service has taken place and will be implemented through the coming year. The Quality Report discusses the redesign of Mental Health pathways and this will remain a priority for both Doncaster CCG and RDaSH through 2014/15. We believe that the Trust remains committed to delivering high Quality Services and further strengthening of the processes by which performance and quality is measured.

Key successes during the year have included a successful Inspection from CQC that concluded that RDaSH was compliant with all the necessary Essential Standards that were included in the inspections. In addition to this the Trust made significant progress and achieved many of the outcomes identified through the CQUIN scheme for both mental health services and community based nursing services. These achievements have provided some solid foundations to support the developments for 2014/2015.

There is a clear focus for all health care providers to provide safe care that avoids harm to service users and we believe RDaSH remain committed to this through their own actions and engagement with the wider health and social care community.

The Trust have described their plans to continue this work through the implementation of a range of strategies. Doncaster Clinical Commissioning Group is confident that the provision of safe care is a priority and that strategies are in place that both acknowledge the challenges ahead and build on the successes in 2013/2014.

The Trust continues to work on obtaining patient feedback and have successfully implemented a local family and friend’s type scheme prior to this being nationally required in 2014/2015. This has provided a solid foundation for the implementation of the National Scheme. The Trust will now use this information to enhance the patient experience and quality of care.

We would like to take this opportunity to thank the Trust and all their staff for their continued focus and hard work and we look forward to working with them collaboratively both in the redesign of key services and the delivery of further improvements in the quality of care and experience.

Mary Shepherd
Chief Nurse, NHS Doncaster Clinical Commissioning Group
28 May 2014
NHS Rotherham Clinical Commissioning Group

The CCG welcomes the report and its move to a more transparent format. As noted the trust has responded to some robust commissioning challenges and continues to do so positively.

Good record keeping is essential to delivering quality services and the work done towards improving this is encouraging.

The CCG has also encouraged the engagement of leading clinicians in our work together; we are pleased with the progress this is making, and look forward to even greater clinical involvement in the future.

A programme of regular Board to Board meeting between RDASH and RCCG has been established. It is hoped these will eventually become part of the quality assurance process.

Dr Russell Brynes on behalf of Rotherham CCG
27 May 2014

RDaSH Council of Governors

The Council of Governors is pleased to have been fully engaged in the development of the Quality Report for 2013 - 2014.

Throughout the year Governors have taken opportunities to be closely involved with initiatives to promote and assure quality services within the Trust:

• Governors have been involved in visits to service delivery areas and have been impressed with the quality of accommodation and care delivered to service users;

• There are Governor representatives on the team that completes the Patient Led Assessment of the Care Environment visits;

• Governors were fully engaged in the development of the Francis Declaration for the Trust;

• A group of Governors have attended the Listen to Learn workshops which are focused on ways to involve service users, carers and stakeholders in how we deliver our services;

• Governors have attended service specific user groups to directly engage with users and carers about services e.g. local collaborative meetings;

• Governors regularly attend the Leading the Way with Quality workshops where they engage with staff members to listen to their experiences and opinions.

Governors regularly attend the Board of Directors meeting where they are actively encouraged to engage by asking questions and providing appropriate challenge.

Governors have been involved in the development of the Annual Plan and the Forward Strategy has been discussed at the Council of Governors in February 2014 where participation was encouraged through table top exercises.

The Council of Governors selected the local indicator this year as Delays in Transfer of Care with emphasis on ensuring that the diversity of services offered should be reflected in the audit.

Staff governors have represented the Council of Governors and attended regular meetings with the Trust Quality Report Working Group to develop the Quality Report and take responsibility for informing the Governors of the content and progress. The Staff governors presented a draft of this statement to all Governors at their meeting on 16 May 2014.

The Governors support the content of the report as an open and honest reflection of the Trust’s position. The Council of Governors is looking forward to working with the Board of Directors, staff, service users, carers and public over the coming year to achieve the Quality Priority contained within the Quality Forward Strategy 2014/15.
Annex 2 - Statement of directors’ responsibilities in respect of the quality report

The statement is in the following form:

“The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2013 to April 2014
  - Papers relating to Quality reported to the Board over the period April 2013 to April 2014
  - Feedback from the commissioners dated 28/05/2014
  - Feedback from governors dated 19/05/2014
  - The trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2014;
  - The [latest] national patient survey 2013
  - The [latest] national staff survey 2013
  - The Head of Internal Audit’s annual opinion over the trust’s control environment dated 27/05/2014
  - CQC quality and risk profiles dated May, June, July, October, November 2013 and January, February and March 2014
  - the Quality Report presents a balanced picture of the NHS foundation trust’s performance over the period covered;
  - the performance information reported in the Quality Report is reliable and accurate;
  - there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
  - the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Lawson Pater
Chairman
27 May 2014

Christine Bain
Chief Executive
27 May 2014
We have been engaged by the Council of Governors of Rotherham Doncaster and South Humber NHS Foundation Trust to perform an independent assurance engagement in respect of Rotherham Doncaster and South Humber NHS Foundation Trust’s Quality Report for the year ended 31 March 2014 (the ‘Quality Report’) and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2014 in the Quality Report that have been subject to limited assurance (the “specified indicators”) consist of the following national priority indicators as mandated by Monitor:

### Specified Indicators

<table>
<thead>
<tr>
<th>Specified Indicators</th>
<th>Specified indicators criteria (exact page number where criteria can be found)</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% enhanced Care Programme Approach (CPA) patients receive follow-up contact within seven days of discharge from hospital</td>
<td>This is defined on P33 of the final Quality Report.</td>
</tr>
<tr>
<td>Admissions to inpatient services had access to crisis resolution home treatment teams</td>
<td>This is defined on P34 of the final Quality Report.</td>
</tr>
</tbody>
</table>

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the specified indicators criteria referred to on pages of the Quality Report as listed above (the “Criteria”). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual (“FT ARM”) and the “Detailed requirements for quality reports 2013/14” issued by the Independent Regulator of NHS Foundation Trusts (“Monitor”).

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the “Detailed requirements for quality reports 2013/14”;
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the “2013/14 Detailed guidance for external assurance on quality reports”.

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the following documents:

- Board minutes for the period April 2013 to March 2014;
- Papers relating to Quality reported to the Board over the period April 2013 to March 2014;
- Feedback from the Commissioners, NHS Doncaster CCG dated 28 May 2014, NHS Rotherham CCG dated 27 May 2014;
- Feedback from Governors, presented at the Governors meeting 16 May 2014;
- The trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2013;
- The latest patient survey dated 2013;
• The latest national staff survey dated 2013;
• Care Quality Commission quality and risk profiles dated May, June, July, October, November, January, February and March; and
• The Head of Internal Audit’s annual opinion over the Trust’s control environment presented to the audit committee 27 May 2014.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the “documents”). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (“ICAEW”) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Rotherham Doncaster and South Humber NHS Foundation Trust as a body, to assist the Council of Governors in reporting Rotherham Doncaster and South Humber NHS Foundation Trust’s quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2014, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Rotherham Doncaster and South Humber NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’ issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’). Our limited assurance procedures included:

• reviewing the content of the Quality Report against the requirements of the FT ARM and “Detailed requirements for quality reports 2013/14”;
• reviewing the Quality Report for consistency against the documents specified above;
• obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
• based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
• making enquiries of relevant management, personnel and, where relevant, third parties;
• considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
• performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
• reading documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.
Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and the Criteria referred to above.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Rotherham Doncaster and South Humber NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2014,

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the “Detailed requirements for quality reports 2013/14”;
- The Quality Report is not consistent in all material respects with the documents specified above; and
- the specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the “2013/14 Detailed guidance for external assurance on quality reports”.

PricewaterhouseCoopers LLP
Chartered Accountants
Leeds
Date:

The maintenance and integrity of Rotherham Doncaster and South Humber NHS Foundation Trust’s website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.
Let us know what you think

Hopefully, our Quality Report has been informative and interesting to you and we welcome your feedback, along with any suggestions you may have for next year’s publication.

Please contact our communications team at:

Woodfield House
Tickhill Road
Balby
Doncaster
DN4 8QN

Email: rdashcommunications@rdash.nhs.uk
Telephone: 01302 796204/796282/798134

Join us as a member and have a say in our future plans

A representative and meaningful membership is important to the success of the Trust and provides members of our local communities the opportunity to be involved in how the Trust and its services are developed and improved. Membership is free and the extent to which our members are involved is entirely up to them. Some are happy to receive a newsletter twice a year while others are keen to be involved in consultations and come along to meetings. Some have even become members of our Council of Governors. For further information please contact our Foundation Trust Office on:
Freephone 0800 015 0370
Email: ftmembership@rdash.nhs.uk

Check out our website

The RDaSH website provides comprehensive details of the Trust’s services and where they are provided, information about mental health and learning disabilities, what to do in a crisis situation, updates on Trust initiatives and links to other useful websites. There is also a section about Foundation Trust membership under the ‘Information for the Public’ heading, where there is an opportunity to sign up online.

Visit www.rdash.nhs.uk to find out more

This Quality Report can be found on the NHS Choices website at www.nhs.uk. By publishing the report with NHS Choices, RDaSH complies with the Quality Reports Regulations. This report can be made available in a variety of formats, available on request.
Annual Plan: this document sets out the Trust’s annual financial forecasts, strategic plans, key risks and priorities

BME: Black and Minority Ethnic

CAMHS: Child and Adolescent Mental Health Service

CCG: Clinical Commissioning Group

CDiff: clostridium difficile

CDW: Community Development Worker

CGAS: Children’s Global Assessment Scale

CPA: Care Programme Approach – the framework for good practice in delivering mental health services. CPA aims to ensure that services work closely together to meet service users’ identified needs and support them in their recovery.

Cluster: a group of service users with similar diagnoses and needs.

COG: Council of Governors

CQC: Care Quality Commission

CQUIN: Commissioning for Quality and Innovation

Dashboard: summary overview of key areas of performance

DCIS: Doncaster Community Integrated Services

DRE: Delivering Race Equality

DSSA: Delivering Same Sex Accommodation

FT: Foundation Trust

KPIs: Key Performance Indicators

LD: Learning Disability

LiNKs: Local involvement networks

LWQ: Leading the Way with Quality

Maracis: A computerised system used to keep service user profiles and records.

MHMDS: Mental Health Minimum Data Set

Monitor: Independent regulator for foundation trusts

MRSA: Methicillin-resistant staphylococcus aureus

MWRV: Managing work related violence and aggression

NAPT: National Audit of Psychological Therapies

NIHR: National Institute for Health Research

NHS: National Health Service

NHS England/NHS Commissioning Board: Formally established as the NHS Commissioning Board on 1 October 2012, NHS England is an independent body at arm’s length to the Government.

NHSLA: National Health Service Litigation Authority

NICE: National Institute for Health and Clinical Excellence

NRLS: National Reporting and Learning Service

NSF: National Service Framework

OPMHS: Older People’s Mental Health Service

OSC: Overview and Scrutiny Committee/Panel – a local authority body which scrutinises and makes recommendations regarding public services provided by the Trust.

PEAT: Patient Environment Action Team

Pbr: Payment by Results

PCT: Primary Care Trust

POMH: Prescribing Observatory for Mental Health UK

Productive Mental Health Ward Programme: a programme of positive changes to ward processes such as handovers and mealtimes, incorporating service user feedback and participation which have been sustained and embedded into practice.

QIPP: Quality, innovation, productivity and prevention

QOF: Quality Outcome Framework

Quarter 1: April, May, June.

Quarter 2: July, August, September.

Quarter 3: October, November, December.

Quarter 4: January, February, March.

RDaSH: Rotherham Doncaster and South Humber NHS Foundation Trust

RAP: Referrals, Assessments and Packages of Care

SARN: Summary Assessment of Risk and Needs

SHA: Strategic Health Authority

SI: Serious incident – an unexpected occurrence requiring investigation

Service engagement scale: an assessment to help improve the level of service user engagement with services e.g. attending appointments.

TBD: Trust Business division

Tool/Toolkit: A package of information and written guidance

UCPC: User Carer Partnership Council

UCRG: User Carer Research Group

Validate: prove valid, declare, provide evidence for