Rotherham Doncaster and South Humber NHS Foundation Trust

Annual Quality Account 2022/23

V12

RDaSH leading the way with care

Quality Account 2022/23

1. Statement on Quality from the Chief Executive

Having started as Chief Executive in March 2023, it is my pleasure to provide an overview of the 2022/23 Quality Account. This is a report which provides a great deal of information on how safety is assured in the organisation and the work we are doing to improve quality.

The past year has seen the country begin to move beyond the pandemic and to try, in the health service, to re-establish services. We recognise that in our communities and for our staff much has changed and so in some cases services will be provided in different ways now on a long-term basis. What is unchanged is the need to be open and candid about what we do well and what needs to be better. I would hope that this report will help to demonstrate that frankness.

The report opens with feedback on the priorities set for 2022/23. A lot of work has gone on to try and deliver improvements. Our audit programmes and other activities will continue to assess the success of those efforts, and the report more generally describes a pattern of strong compliance with audit recommendations. That focus will continue. For 2023/24 we have some fundamental work to do too on how we manage and learn from incidents, complaints, and risk identification across Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) – and our work to ensure that these tools are applied equitably among communities who rely on our care. I will report back on that work in next year's report and throughout the year in our public board of directors' meetings.

Serious incidents form a vital part of our work on safety. During 2023 nationally the approach taken to investigating and learning from incidents will change. This report details our work to learn from SIs – and highlights a focus on our role in suicide prevention, working alongside organisational partners. Serious incident learning is central to the work of the Trust and its Board and in the year ahead we will begin to adapt how that learning is shared organisation wide.

The Trust benefits from a strong culture of education and a deep tradition of research. The report provides a brief snapshot of that work. Yet it is fundamental to how we improve outcomes. By applying national tools like NICE audits, and by contributing to experimental work locally, we can identify what we need to do to provide the best care to local people. The report concludes with detail of your opinion counts, and compliments submitted, and we know that there is much to be done to maintain those positive experiences of the work our dedicated teams do.

Most services provided in the Trust are externally rated as outstanding or as good. However, the overall position of the Trust remains requires improvement. This coming summer and winter, we are re-inspecting our services to see whether sufficient change has been made. The actions recommended by the Care Quality Commission (CQC) have been done. But we need to remain curious about whether we have consistency of care, between our sites and units, in the evening as well as the day. We will be working with patient-led organisations, including Healthwatch in our three places, in forming these judgments.

It is important that the services offered by the Trust, for children and adults, in community and hospital settings, are provided fairly and equitably to people of all backgrounds, faiths, ethnicities, and genders. We are committed to ensuring that we work free of discrimination and with a positive attitude to diversity. This work is a priority for us in the coming year.

The national staff survey tells us something about how colleagues who work in the Trust view the experience of caring, and indeed what they think about the safety of services. The Trust

continues to evaluate well on these measures. In this report, we also share some data about patient views, and compare that to other Trusts. On almost every measure patients report positively on RDaSH. We recognise that we have work to do to make sure that every patient can name and contact those caring for them – and to ensure that care plans are personalised.

We would welcome feedback on the report as we look to improve the care that we provide.

As Chief Executive of the Trust, I confirm that to the best of my knowledge the information provided within this 2022/23 Quality Report is accurate.

Our annual report 2022/23 contains further information on 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@nhs.net

Toby Lewis
Chief Executive
30 June 2023

2.1 Our Priorities for Improvement

Continuous quality improvement is at the heart of everything we do, and we aim to provide the insight, tools, support, and expertise to ensure that the care delivered by Rotherham Doncaster and South Humber NHS Foundation Trust reflects the three pillars of safety and quality:

- Insight
- Involvement
- Improvement

The Trust Strategic Plan for 2021-23 reflected some of the challenges that COVID 19 had highlighted, particularly in respect to the weight of activity for the Trust and the disproportionate impact COVID 19 has had on members of our society. As we come to the end of that Plan, this section identifies the achievements made in terms of quality and safety and our priorities for the forthcoming year as we finalise the development of a new strategic plan.

The Strategic Ambitions are supported by a set of Strategic Objectives and two Enabling Objectives which are shown in our Plan on a Page below.

A revised Trust long term strategy will be published by September 2023, with safety and quality at its core. This is likely to be supported by a specific plan to address new safety and quality priorities for the Trust.

2.1.1 Priorities for Improvement 2022/23 and our progress against these

In 2022/23, we continued to address the ambitions and commitments identified in the Safety and Quality Delivery Strategy and made significant achievements as detailed in the tables below.

Table 1: Insight	
Priority: We will improve our understanding of patient safety by developing and drawing from multiple sources of information.	
• Improve the availability of 'live' patient safety data for clinicians and for assurance by implementing a programme of 'digital wards' across the Trust, by March 2022 - this is continued into 2022/23	
Will be achieved by:	Achievements
Developing an insight report for each Care Group to further inform patient safety improvement activity by Q1 2022/2023	• We have expanded the use and reporting function of the incident reporting system to further enhance incident reporting and action taken • Each care group has access to their own incident data live dashboard on Ulysses (The Trust's incident management system) • We have continued to develop the Integrated Dashboard and Patient Safety Dashboards to report against key themes and action taken • Reporting timeframes on incidents and closures are monitored on a monthly basis. • A task and finish group has been commenced on 2 May ensure that incidents are closed within the required timeframes and learning is shared.
Further work to develop and strengthen the use of Tendable by Q2 2022/2023 *(Tendable is an online quality improvement assurance tool which supports services to undertake quality inspections/audits)*	• Review of compliance undertaken identifying any challenges and difficulties • Task and Finish group established led by Head of Quality to troubleshoot any barriers to usage within inpatient services • Developed a trajectory of application within community team settings. • The app will be relaunched in 2023 with the aim of achieving full implementation – see section 2.1.2.
Implementing the new National Reporting and Learning System when it is made live (national implementation delayed in 2021/22 by Covid-19)	The Learning from Patient Safety Events (LFPSE) system has been mapped against the trust incident management system, Ulysses. From Q4 2022/2023, the test system has been operational and the required test incidents have been submitted to LFPSE pending feedback from NHS England. Post-feedback and discussion with senior leaders, a "go-live" date for implementation of the live LFPSE system will be set in Q3 2023/2024. The local risk management system (LRMS) is compliant with LFPSE and there are clear processes for communication with the LFPSE team at NHS England to provide assurance and pace with successful implementation.

	In Q1 and Q2, 2023/2024, the Patient Safety Incident Response Framework (PSIRF) process is currently being reviewed and will be mapped by Ulysses. This will be included in a test phase and then fully included in the Ulysses incident management system.

Table 2: Involvement	
Priority: Our patients, carers, families, staff and partners have the skills and opportunities to improve patient safety across the whole system.	
• Strengthen patient safety culture by establishing patient safety specialists within our workforce, to lead on safety within their service by Sept 2021 - this is continued into 2022/23 • Work to adapt our safety and quality culture to expand patient safety thinking by expanding the roll out of Safety Huddles and Schwarz Rounds. This includes doubling the number of Schwarz Rounds by March 2023 • Develop an approach to improve the response rate to the Family & Friends Test by September 2021 - this is continued into 2022/23 • Increase the patient voice in patient safety work by creating patient safety partners (who may be patients, their families and carers and other lay people) by December 2021 - this is continued into 2022/23	
Will be achieved by:	Achievements
Developing and recruiting patient safety partners by Q4 2022/2023	Two patient safety partners were successfully recruited and commenced in post in Q4 2022/2023. Patient safety partners are actively involved in the work to implementation of PSIRF, especially in relation to patients and families/carers. They are also active in learning response forums such as the pressure ulcer review panel.
Development of a patient safety training programme in line with the national syllabus by Q1 2023/2024	A Learning Needs Analysis (LNA) has been completed in Q1 2023/2024 and engagement with training providers, approved by NHS England, has been undertaken to achieve compliance with the national syllabus. Level 1 and Level 2 training outlined in the national syllabus has been available via e-learning for all employees to complete on ESR and this is monitored by care groups monthly. The LNA is being reviewed for approval in relation to PSIRF training with the aim of implementation in Q2 2023/2024.
Further development of a patient safety web page including learning from incidents by Q1 2022/2023	A Patient Safety webpage has been developed which includes: • NHS Patient Safety Strategy • Patient Safety Messages • A Just Culture Guide • Learn from Patient Safety Events (LFPSE)

	• Patient Safety Incident Response Framework (PSIRF) An Organisational Learning webpage has been created and is being further developed. This includes copies of all clinical learning briefs developed

Delivery of a medication safety improvement programme by Q2 2023/2024	• IR1 reported incidents
	  ○ All IR1s are reviewed to determine if medicines are involved in the incident
	  ○ All medicines related incidents are categorised with respect to severity, nature of incident
	  ○ All incidents where a patient has come to harm or an intervention was required to ensure 'no harm' are reported through MMC on a monthly basis
	  ○ Trend reports are received by MMC on a rolling program based on type of incident or in response to an emerging concern
	• Log maintained of responses to Clinical Alert System and other medicines alerts which are reviewed by Medicines Management Committee (MMC) on a monthly basis
	• Developed a medicines related training portal to enable on-line registering to a program of training, this training is delivered via teams which has enabled wider and more frequent access to the training. Additionally, there are a new series of therapeutic update training sessions regarding medicines management and particular drug groups, this continues to be developed.
	• Assurance reporting is undertaken routinely on electronic prescribing activity, including allergy status recording, medicines reconciliation at admission and a pharmacy overview care plan for inpatients. These are all regularly reviewed through MMC
	
	Future plans
	A Deputy Chief pharmacist starts in mid-May 2023 part of whose role is MSO (Medicines Safety Officer). We will at that stage
	• review the progress over the last year and formulate a coherent strategy to improve on medicines safety.
	• participate more regularly in local and regional MSO networks to share/ adopt good practice.

Development of an incident reporting system for patients by Q4 2022/2023	This is part of the Learn from Patient Safety Events (LFPSE) process where Patient and family will also be able to report events regarding care received. This will be launched during Q2 2023/24.

Development of a patient safety partners forum/ focus group Q4 Q2022/2023 that includes Champions and patient safety partners	• Patient Safety partners have been recruited and are undergoing induction. • Patient Safety Champions in place and we are looking at specific roles for champions including ligature risk leads etc. • A forum will be developed in 2023/24
The Patient Safety Specialists will have completed the national training in time scale set by the national team	Head of Patient Safety and Deputy Director for Organisational Learning and Inquests have undertaken training level 1 & 2. Awaiting national roll out of levels 3,4, and 5.
Developing responding to complaints training for front line staff by Q1 2022/2023	Complaints training was commissioned and *Effective Written Responses to Complaints in the Public Sector* was delivered to front line staff, managers and investigators during Q4 2022/23
Developing and implementing an improvement plan for enhancing earlier resolution to complaints and how the learning is shared and influences future practice, reflecting the national standards by Q1 2022/2023.	Mapping and learning review being undertaken with completion Q2 2023/24.

Table 3: Improvement	
Priority: Our improvement programmes will enable effective and sustainable change to enhance the safety and quality of our services.	
• Improve compliance arrangements for ligature risk reduction, taking into account current and emerging guidance, and best practice by Q4 2021. This also includes implementing all 'must do' and 'should do' ligature risk reduction actions identified through the Care Quality Commission 'well led' Inspection • Improve the systematic focus on quality and safety based on national good practice by finalising a Trust wide Quality Management System, after testing in two specialities, by the end of March 2022 - this is continued into 2022/23. • Improve safe staffing levels on wards by increasing staff recruitment and retention rates to reduce turnover by at least 1.5% points by the end of March 2023 • Review case loads for staff working in the community to inform funding discussions with commissioners.	
Will be achieved by:	Achievements
Development a handbook for leads on managing complaints by Q1 2022/2023	• The handbook has been developed and approved by the Serious Incident Group in July 2022 • The handbook is being reviewed as part of the Complaints Improvement Plan
Development of ligature risk heat maps to further inform areas of focus in clinical environments by the Patient Safety Specialist by July 2022	• Completed awaiting finalising of 2. • These are now on wards and in information packs
Implementation of an alternative risk assessment tool to the Manchester ligature tool, when finalised by the Directors of Nursing Forum.	The National Forum of Directors of Nursing for Mental Health are leading work on developing an alternative tool to be used and we have had no further information on when this will be available. In 2022/23 Trust risk assessments were updated to include low level ligature risks and action to be taken.

Developing a restraint reduction strategy and achieving a 10% reduction in incidents by the end of 2022/2023	• A consultation event was held in 2022/23 • A policy on the Mental Health Units Use of Force Act-in place and approved. This will be reviewed in 2023/24 • Information for patients on their rights and expectations regarding the Use of Force disseminated to all clinical areas. This will be reviewed in 2023/24 • A designated responsible person is in place in respect of the Mental Health Units Use of Force Act. • Arrangements in place for reporting of incidents where force has been used • Training for staff is in place and complaint with BILD accreditation • QUIT embedded across inpatient areas providing support and nicotine replacement to support patient experience and reduce withdrawal from nicotine • Safer Engagement Network and Innovation Group in place which oversees the work • Restraint reduction strategy to be developed 2023/24
Publishing a sexual safety charter and agreeing the incident reduction target for 2022/2023	• Developed a sexual safety leaflet for patients on admission • Developed a sexual safety charter • Routine reporting on sexual safety to Quality Committee as part of the Patient Safety report ensuring a line of sight from floor to Board • Completed cascaded to Matrons at ERICA
Continuing the work of the suicide prevention strategy: **Suicide Prevention** • To look at the learning from Serious Incidents linked to suicide and suspected suicide to identify any key demographics or recurring themes. • To review RDaSH data against all place-based data • To undertake a review against the NCISH self audit toolkit and continue to map against 10 steps to safety • Monitor and audit against work undertaken including Ligature risks, observations, use of Oxevision **Learning from Deaths** • Embed the In-patient quality standards as a key piece of work in relation to patient quality and safety • To undertake a collective review of learning Disability deaths to identify any themes, trends, and demographics	• Part of suicide prevention groups at ICS level and at Place base. • Observations Policy implemented, training undertaken with further ongoing review being undertaken in Q4 and Q1 and 2 2023/24 • Ligature deep dive work done around self ligaturing with a plan for further review of demographics and patient history. Managed through ERICA • Mapped the Trust against 10 Points to Patient Safety. • Internal bathroom doors changed across organisation to ensure that they do not provide a ligature point. • Environmental risks closely monitored at the ERICA meetings. • Strengthened relationships with Drug and Alcohol services provided by third sector organisations in Rotherham and North Lincs to work closer with RDASH. • Additional controlled access entrance door added to lobby at Swallownest Court

• Drug and Alcohol to work in partnership with Doncaster ;Public health to review and understand deaths in temporary accommodation, hostels, and houses of multiple occupancy To continue to develop working relationships and integrated care across mental health and drug and alcohol services with a particular focus on dual diagnosis care and management	• Single point of contact for each Trust Crisis Team • Review being undertaken of learning Disability deaths due for completion Q2 2023/24 • In patient standards developed and will form part of a Trust wide strategy • Partnership work commenced with Doncaster council and other partner agencies in April 2023 looking at deaths in the homeless.
Continuing the Stop the Pressure Campaign to reduce health inequalities relating to pressure ulcers, improved risk assessment and evidence-based intervention by Q2 2022/2023	Stop the Pressure Campaign continues and workstreams have included developing a three level educational package for staff, In the Know practice updates and a forward plan to update electronic Care Plans to ensure they are patient centred.
Expanding the STOMP and STAMP programme by Q2 2022/2023	A work stream is actively reviewing audits around transitions and the STOMP agenda. Further work steams have been developed to undertake targeted work in relation to training staff in the role of Learning Disability Ambassador's and reviewing how we receive feedback, concerns and complaints and embedding "Ask Listen Do".
Demonstrating compliance with Learning Disability Improvement Standards by 2023/2024	This is monitored by the Learning Disability Quality Circle and Quality Committee. A six monthly report is produced including benchmarking against the standards.
Holding an annual patient safety conference by Q3 2022/2023	The Patient Safety conference did not take place during 2022/23 due to serviced demands. A conference will be held in 2023/24.
Developing and building a Just Culture approach to safety and learning by Q4 2022/2023	• Safety Huddles are being held across all inpatient areas and in some community areas and the feedback is very positive regarding how they are supporting patient safety, staff safety and reflection, including being a key forum to share good practice and ideas. These are being strengthened • Schwartz rounds are in place and the feedback from participants is excellent, highlighting how they are supporting the work of professionals • Just Culture approach embedded in SI processes • During 2023/34 daily incident reviews and Roll out SWARM model will be rolled out and implemented • Trust wide organisational learning forum in place for 9 June 2023
Developing a Just Culture guide with Human Resources to ensure it is reflected in policies by Q4 2022/2023	The Just Culture principles and ways of working are being considered and applied when we review the HR policies as part of their scheduled review. The HR team and managers have incorporated the principles into employee relations matters. Upon

	review in Q4 2022/2023, there has been a reduction in cases proceeding via the disciplinary policy. This work will be further strengthened during 2023/24. In Q4 2022/2023, the culture team have led on completion of a Just Culture self-assessment tool, engaging colleagues across the Trust to identify a baseline of where the Trust is at and seek areas for development to fully adopt a Just Culture approach. This will inform future strategies developed across 2023/2024.
Delivering training on Just Culture to staff across the organisation by Q4 2022/2023	The Trust has commissioned training programmes for colleagues to attend the 5-day accredited programme, which has been further supported with a bespoke Board training programme which has been achieved by Q3 2022/2023. Three cohorts have successfully completed the training and will support with the development of the Trust Just Culture strategy. The Trust will look to further roll out training in 2023/24 across the organisation to meet specific job roles and specialities with regards patient safety and staff wellbeing.
Implementing a Patient Safety Response Framework by Q3 2022/2023	There is a clear implementation plan and agreed forums to monitor and progress PSIRF. There is collaborative approach with ICB colleagues to support with providing assurance and eventual sign-off of the Patient Safety Incident Response Plan (PSIRP). There is dedicated resource to the implementation of PSIRF, and strong engagement with stakeholders.
Reviewing current resources to support implementation of the Patient Safety Incident Response Framework by Q1 2022/2023	Process mapping and review of current resources has been undertaken in Q4 2022/2023. There are processes in place to continuously review resources required for successful implementation of PSIRF.
Implementing the national patient safety measurement principles when published Q1 2022/2023 (when national measures for improvement will be set)	The Trust recognises and works to the safety measurement principles outlined in the National Patient Safety Strategy produced by NHS England and Improvement (page 22). The national measure for improvement is linked to objectives and aims to allow the Trust to demonstrate whether the changes are making improvements. **A Just Culture of Safety** The Trust has achieved successful engagement with colleagues at all levels of the organisation in

	completing and contributing to the Just Culture self-assessment framework. Proxy Indicators such as staff suspensions and absence management have noted a reduction in Q3 and Q4 2022/2023. This will continue to be monitored in 2023/2024. In 2023/2024, the Trust will enhance monitoring of existing culture metrics, such as the NHS Staff Survey to obtain staff perceptions of fairness and effectiveness of patient safety management. In 2022/2023, the Trust received positive staff survey results and will continue to support development in this area. **Patient & Carer Engagement** There is a developed People First Group forum, and recruitment of two Patient Safety Partners. Roles will be measured based on engagement and representation from groups in this area. **Continuous Learning & Improvement** The Trust has developed local Organisational Learning forums in each care group to share local and organisational learning from incidents and learning from death events. An organisational learning forum will commence in Q2 2023/2024, and this will be a forum of robust governance for the PSIRF. The Trust engages in incident learning forums with all Integrated Care Boards; this will continue with a greater emphasis on learning and oversight of the provision of safe care and enhance cross-system working. **Leadership and Quality Improvement** The Trust has an established Quality Improvement programme. The Quality and Safety Strategy is in place and the measurements are reviewed at governance forums to support staff in keeping people safe. Proxy Indicators such as anonymous incident reporting, whistleblowing and Freedom To Speak Up concerns continue to be monitored by the senior leadership teams and board to create a well-led patient safety culture.
Reduce the number of patients suffering three or more falls by 10% by the end of Q2 2022/23.	• New Trust Falls Lead in place • Review undertaken • Action plan in place for 2023/24

Continue to monitor safer staffing for community nursing services from December 2021 onwards, including progressing automation of caseload tool and furthering international recruitment opportunities	• Implementation of the Community Nursing Safer Staffing Tool, as an acuity and dependency measure for caseloads is on track. • Community safe staffing is included in the Quality Report, noted as assured in March 2023. • International Recruitment pipeline process continues for mental health and adult registered nurses. It has been expanded into Allied health professionals such as Occupational Therapy and Podiatry.

2.1.2 Safety and Quality Priorities for 2023/24

Table 4 below sets out the safety and quality priorities for 2023/24 and how we will achieve this programme.

Table 4: Safety and quality priorities for 2023/24	
What is our priority?	**How will we achieve this?**
1. To improve the experience of care and the opportunities for involvement across all care groups and corporate departments In response to the local, regional, and national context, we are making 5 key pledges which uphold our commitment to continuously improve the experience of care for people; patients, carers, and families, and to ensure that patient and public voice is core to our service delivery. Within the **LIVED** experience plan- We will harness the power of **lived experience.** We will enhance patient and public **involvement** and partnership opportunities with our communities. We will strengthen our **volunteering** offer. We will meaningfully understand patient and carer **experience** and take actions to share good practice and make improvement where required. We will establish a **diverse** Trust membership, Board and Council of Governors.	• Q1/Q2: we will launch a coproduced LIVED Experience plan (Patient Experience and Involvement Plan) that will include the 5 key pledges for improvement. • Q1/Q2: we will establish a programme plan and governance structure for the implementation of projects and activities that deliver each of the pledges and several We Will statements within each pledge. The plan will be led by a triple leadership framework; staff, patients, community. • Q1/Q2- We will develop Patient Experience Feedback Volunteer role descriptions for inpatient and community services, and launch local recruitment drives, in support of the Tendable system roll out, and other systems for patient feedback. • Q1-Q4: we will work with the South Yorkshire Integrated Care Partnership Strategy, to develop a coproduction framework for South Yorkshire • Q1-Q4: we will provide leadership support to the South Yorkshire MHLDA Provider Collaborative to embed involvement and coproduction within the provider priorities.

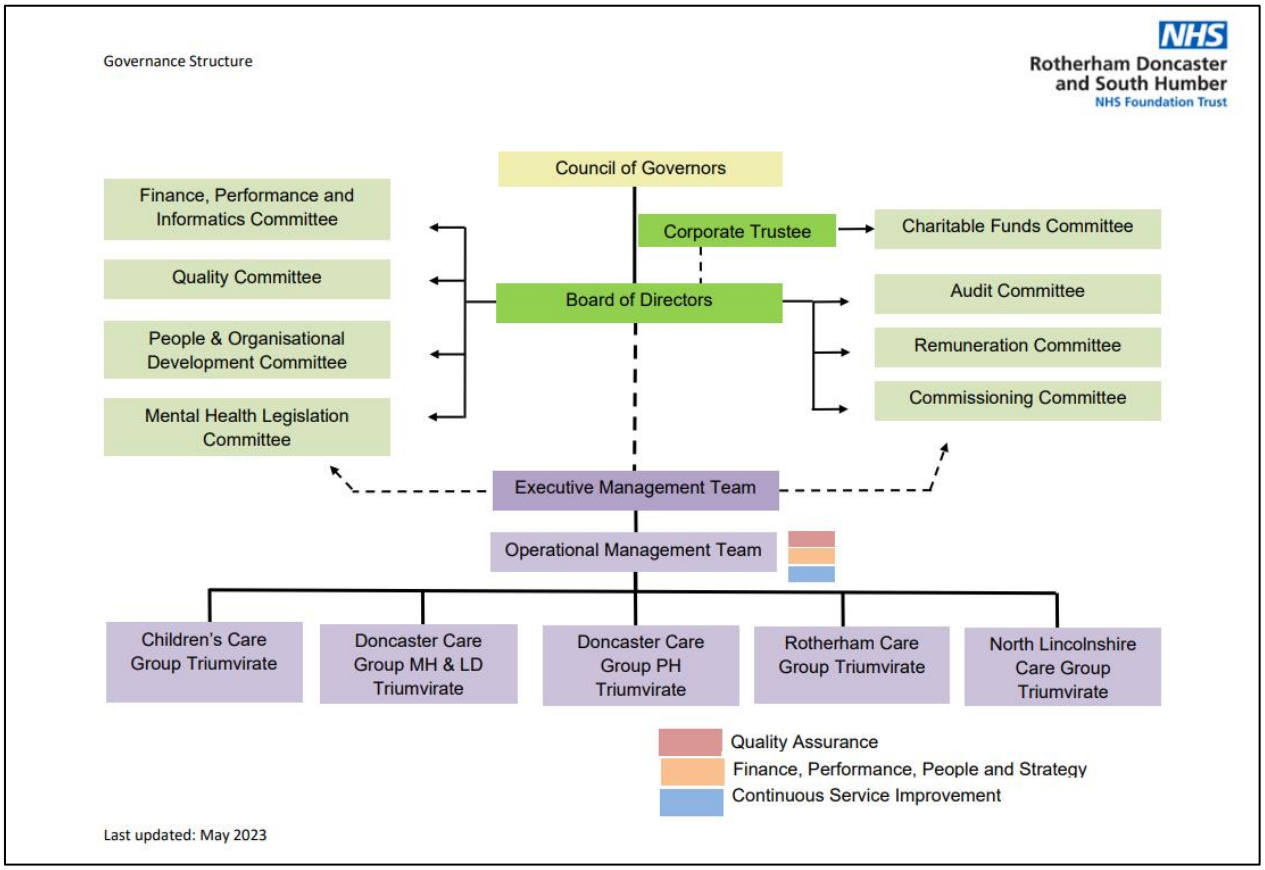
Table 4: Safety and quality priorities for 2023/24	
What is our priority?	**How will we achieve this?**
2. To implement a Trust wide quality accreditation process and ensure that 'CQC readiness' is 'business as usual' RDaSH works to deliver the highest quality care for our patients and many improvements have and continue to be made. Peer led quality reviews can help us to understand how well we have implemented these improvements and if they have made a difference. They will also help us to be prepared for any future CQC inspection by reviewing ourselves against their standards, and key lines of Enquiry (KLOEs). An accreditation process will help services to demonstrate their current level of quality and aspire to improve.	• Each care group and team will undertake our internal accreditation process which mirrors the CQC assessment framework. • Each area will have a peer review but also undertake a self-assessment. • Action plans will be produced, monitored and supported if there are any shortfalls.
3. To improve our complaints process The NHS Complaint Standards, model complaint handling procedure and guidance set out how organisations providing NHS services should approach complaint handling. They apply to NHS organisations in England and independent healthcare providers who deliver NHS-funded care. Building on the good practice that already exists, they provide a consistent approach to complaint handling across the NHS. They will: • help your organisation deliver what service users want when they make a complaint • support staff to deliver good complaint handling day in, day out.	• The complaints and investigation team are to be realigned to the care groups in order to promote and embed the new complaints standards. • There will be monitoring of the complaints recovery plan to include response times, training and action plans that may be required where care falls below the standard that is expected • Through early 2023/2024 work will be undertaken to ensure that this is collected more thoroughly for the patient (whether or not they are the complainant) and an analysis of the gender and ethnicity of patients/complainants as against our treated population and as against the resident population.
4. To fully implement the Patient Safety Incident Response Framework NHS England launched the Patient Safety Incident Response Framework in Autumn 2022, with the aim that all NHS funded services will achieve implementation by Autumn 2023. This will replace the Serious Incident Framework (NHS England, 2015) and remove the serious incident category and will replace Root Cause Analysis (RCA) for a systems-based approach to investigations. Organisations will develop their incident priorities where maximum learning and quality improvement can be achieved. The 4 strategic priorities of PSIRF are:	• In Q2 we will agree our incident priorities and identify appropriate learning response tools based on our patient safety data analysis, within RDaSH, ICBs and our regulatory partners. These priorities will be included in our Patient Safety Incident Response Plan (PSIRP) and will outline areas where we will undertake Patient Safety Incident Investigations (PSII). • In Q2/Q3 we will continue to engage with colleagues, patients, families, carers and the wider public as to our incident priorities, our approach to learning response tools and how we will engage those affected by incidents and identify how we will measure effective engagement and satisfaction.

Table 4: Safety and quality priorities for 2023/24	
What is our priority?	**How will we achieve this?**
• Compassionate engagement and involvement of those affected by patient safety incidents. • A wide-range of system-based approaches are applied to learn from patient safety incidents. • Considered and proportionate responses to patient safety incidents. • Supportive oversight to strengthen response system functioning.	• In Q2, we will launch the PSIRF training programme to allow for further insight, and develop expertise in systems approach to patient safety incident investigations which will allow us to maximise learning. • In Q2, we will develop our PSIRP based on our patient safety incident profile, outlining our governance processes for signing off PSII, identify learning and support and share this across the organisation, working with our ICBs. • In Autumn Q3, we will launch PSIRF and FPSE across the Trust. We will continue to embed and measure implementation of PSIRF in Q3/Q4, making any changes as they arise based on our feedback and measurables.
5. To continue to improve the effectiveness of clinical audit within the Trust	• A proposed clinical audit calendar is being agreed with the care groups. This will include mandated national audits. • Clinical audit is central to our quality improvement and care standards. Actions will be monitored and supported should any audits fall below the expected quality standards.
6. Health and safety	• A health and safety calendar of audits is being developed and agreed with the care groups
7. To use data and triangulation of data to support quality improvements This will be a combination of Tendable, Ulysses evidence vault and roll out of the integrated quality performance dashboard. Metrics are being agreed and will be monitored as part of care group assurance.	• Quality improvement metrics will be agreed and will be monitored against
8. To move from minimum safe staffing to optimal staffing on inpatient units and in community services. We aim to enhance Inpatient flow and improve inpatient experience. • An evidence-based acuity and dependency tool (MHOST NHSE) has been launched to gather data to provide full insight into how RDaSH current establishments or ratios match the needs of patient care. • This is replicated using a tool for mental health community staffing and for community nurse safe staffing (CNSST NHSE TOOL) • The person receiving care, and their support network as they wish, should be at	• Fully implement MHOST across all services • Undertake analysis and provide evidence to support that inpatient flow has been improved • Provide evidence of where and when minimum staffing has moved to optimal staffing

Table 4: Safety and quality priorities for 2023/24	
What is our priority?	**How will we achieve this?**
the centre of all decisions and processes around their care.	
9. The Trust is fully engaged with the national inpatient quality standards programme. We aim to enhance Inpatient flow and improve inpatient experience Nationally, there is a programme to support cultural change and leadership in mental health care services. RDaSH will focus on the following: • Our inpatient services will provide exemplary care against the new national standards This will build confidence in our patients in terms of accessing services (our complaints will reduce as should our length of bed stay) • It will help build pride in people providing services • Our patients will not be cared for away from where they live, we will have no out of area placements. We will support our patients within the RDaSH footprint. Our patient experience will increase.	• We will be able to evidence where inpatient services have met the national standards • We will evidence a reduction in the number of out of are placements • We will evidence improved patient experience

2.1.3 Measuring and reporting of the priorities for improvement

The following governance structure is in place:



The structure and system outlined above is being revised. The replacement of the EMT, as shown, will lead to an organisation led by the Clinical Leadership Executive, which will work across the organisation to improve outcomes.

The reviewing, monitoring and measuring of quality has been reported to Trust Board through the Trust's governance structures (via the Quality Committee and the Mental Health Legislation Committee and their subcommittees/groups) by various reporting methodology including:

- Quality Dashboard Reports
- Board Assurance Framework (BAF)
- Quality Committee Summary Report to Board
- CQC Inspection Reports and Action Plans
- Quality Priorities Progress Report
- Internal Audit reports
- 'Deep dive' investigation/review reports

Board Assurance Framework (BAF)

The Board Assurance Framework (BAF) provides the Board of Directors with assurance that appropriate arrangements are established regarding the effectiveness of risk controls in the Trust. These are the controls that have been put in place to mitigate the Trust's exposure to risk in the achievement of its strategic objectives.

The review and refresh of the BAF was undertaken for 2021/23 aligned to the new strategy and seven new strategic risks were agreed, five of which relates to quality:

- SR 5 - If the Trust does not develop, approve and deliver the Clinical Strategy, then this may impact on patient safety, patient experience, clinical effectiveness and regulatory compliance.
- SR 7 - If a significant destabilising event occurs then the delivery of services, financial performance and wellbeing of staff may be impacted.

The identified risks were regularly reviewed and monitored throughout 2022/23 by the lead executive Director, the relevant Committee, and the Board of Directors. Reporting includes the identified gaps in controls and/or assurance along with their associated actions and the progress being made.

Underpinning the strategic risks on the BAF are the relevant operational risks from the individual Directorate/Care Groups. Quality related risks are captured on the Nursing and Quality, or Care Group Risk Registers and an overview is presented to the Quality Committee on a regular scheduled basis. All 'extreme' rated risks have a director as the risk lead for review and update and are monitored by the Board of Directors on a monthly basis. During 2021/22 there were 3 extreme risks identified relating to:

- Children and Young People Eating Disorder Service
- North Lincolnshire inpatient staffing
- North Lincolnshire medical staffing

Quality Committee Summary Report to Board

The Chair of the Quality Committee (Non-Executive Director) presents a Quality Committee summary report (including highlights and escalation of any issues/matters relating to quality) to the Public Board of Directors meeting. This meeting is bi-monthly.

Quality Dashboard Reports

The quality dashboards provide assurance internally and externally via the following routes:

Table 5: Quality Dashboards 2022/23

Quality Dashboard	Frequency	Internal Assurance	External Assurance
Patient Safety: • Incident Reporting • Duty of Candour • Serious Incidents • Suicides • Complaints • Patient Advice and Liaison Service (PALS) • Your Opinion Counts • Friends and Family Test • MP Letters • Safeguarding Adults • Safeguarding Children • Infection Prevention and Control • Falls – High risk areas (*not included in the Children's Care Group dashboard)* • Pressure Ulcers • Reducing Restrictive Interventions • Medicines Management	Monthly	• Care Group Assurance meetings (Quality)	• Doncaster ICB • Rotherham ICB • North Lincolnshire ICB
Clinical Effectiveness: • Deprivation of Liberty Standards • Reducing Restrictive Interventions training compliance • Blanket restrictions • NICE guidance • Clinical Audit • Non-Medical Prescribing (NMP) • CQC MHA inspections • Board of Director service visits • Good practice and innovations	Quarterly	• Care Group Assurance meetings (Quality)	• Doncaster ICB • Rotherham ICB • North Lincolnshire ICB

In addition, 'Quality of care' metrics are also reported as part of the Trust's Integrated Performance Dashboard. These have been updated in 2022/23.

Care Quality Commission (CQC) Inspection

The Trust's last CQC Well Led inspection took place in November 2019 and the inspection report was published on 21 February 2020. The Trust received an overall rating of **'Requires Improvement',** with ratings of **'Good'** in the domains of Caring and Responsive and a rating of **'Requires Improvement'** in the domain of Safe, Effective and Well Led. The inspection report can be accessed via:
https://www.cqc.org.uk/sites/default/files/new_reports/AAAJ6960.pdf

CQC identified 33 Must Do actions and 44 Should Do actions as a result of their inspection and all of these actions have now been closed.

Regular updates have provided to CQC during 2022/23 through routine engagement with them.

The Trust's ratings overall and at service level are identified in the figures below, along with comparative rating from the previous inspections. Where there are no comparative arrows, the core service was not inspected during the most recent inspection and therefore the rating remains the same.

During 2022/23, CQC continued to prioritise inspections of Trusts on a risk-based approach. As CQC were assured of the Trust's safety and quality, they did not deem a further inspection to be a priority during 2022/23. CQC receives assurance via their own reporting mechanisms, from information provided by the Trust and through CQC's routine engagement with the Trust.

Figure 1: Trust Overall Rating February 2020

Ratings for whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement → February 2020	Requires Improvement ↓ February 2020	Good → February 2020	Good → February 2020	Requires Improvement ↓ February 2020	Requires Improvement ↓ February 2020

Ratings for the combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Good → Feb 2020	Good → Feb 2020	Good → Feb 2020	Good → Feb 2020	Good → Feb 2020	Good → Feb 2020
Mental Health	Requires Improvement → Feb 2020	Requires Improvement ↓ Feb 2020	Good → Feb 2020	Good → Feb 2020	Requires Improvement ↓ Feb 2020	Requires Improvement ↓ Feb 2020
Overall trust	Requires Improvement → Feb 2020	Requires Improvement ↓ Feb 2020	Good → Feb 2020	Good → Feb 2020	Requires Improvement ↓ Feb 2020	Requires Improvement ↓ Feb 2020

Figure 2: Service Level Ratings Comparative with Previous Inspection Results

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement → Feb 2020	Good → Feb 2020	Good → Feb 2020	Good ↑ Feb 2020	Requires Improvement ↓ Feb 2020	Requires Improvement → Feb 2020
Long-stay/rehabilitation mental health wards for working age adults	Requires Improvement → Feb 2020	Requires Improvement → Feb 2020	Good → Feb 2020	Good ↑ Feb 2020	Requires Improvement → Feb 2020	Requires Improvement → Feb 2020
Forensic inpatient/secure wards	Requires Improvement ↓ Feb 2020	Good → Feb 2020	Good → Feb 2020	Good → Feb 2020	Good → Feb 2020	Good → Feb 2020
Wards for older people with mental health problems	Good April 2018	Good April 2018	Good April 2018	Good April 2018	Good April 2018	Good April 2018
Community-based mental health services for adults of working age	Requires Improvement → Feb 2020	Requires Improvement → Feb 2020	Good → Feb 2020	Good → Feb 2020	Requires Improvement → Feb 2020	Requires Improvement → Feb 2020
Mental health crisis services and health-based places of safety	Good Jan 2016	Outstanding Jan 2016	Good Jan 2016	Outstanding Jan 2016	Good Jan 2016	Outstanding Jan 2016
Specialist community mental health services for children and young people	Good → Feb 2020	Requires Improvement ↓ Feb 2020	Good → Feb 2020	Good → Feb 2020	Good ↑ Feb 2020	Good → Feb 2020
Community-based mental health services for older people	Good Jan 2016	Good Jan 2016	Outstanding Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016
Community mental health services for people with learning disabilities or autism	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017
Substance misuse services	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017

Overall	**Requires Improvement ➔➔ Feb 2020**	**Requires Improvement ➔ Feb 2020**	**Good ➔➔ Feb 2020**	**Good ➔➔ Feb 2020**	**Requires Improvement ➔ Feb 2020**	**Requires Improvement ➔ Feb 2020**

Ratings for community services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	**Requires Improvement ➔➔ Feb 2020**	**Requires Improvement ➔ Feb 2020**	**Good ➔➔ Feb 2020**	**Good ➔➔ Feb 2020**	**Requires Improvement ➔ Feb 2020**	**Requires Improvement ➔ Feb 2020**
Community health services for children, young people and families	**Good Jan 2016**	**Good Jan 2016**	**Good Jan 2016**	**Outstanding Jan 2016**	**Outstanding Jan 2016**	**Outstanding Jan 2016**
Community health inpatient services	**Good April 2018**	**Good April 2018**	**Good April 2018**	**Good April 2018**	**Good April 2018**	**Good April 2018**
Community end of life care	**Good Jan 2016**	**Good Jan 2016**	**Good Jan 2016**	**Good Jan 2016**	**Good Jan 2016**	**Good Jan 2016**
Hospice services for adults	**Good Jan 2016**	**Good Jan 2016**	**Good Jan 2016**	**Good Jan 2016**	**Good Jan 2016**	**Good Jan 2016**
Overall	**Good ➔➔ Feb 2020**	**Good ➔➔ Feb 2020**	**Good ➔➔ Feb 2020**	**Good ➔➔ Feb 2020**	**Good ➔➔ Feb 2020**	**Good ➔➔ Feb 2020**

Ratings for adult social care services

	Safe	Effective	Caring	Responsive	Well-led	Overall
10a and 10b Station Road	**Good April 2018**	**Good April 2018**	**Good April 2018**	**Good April 2018**	**Good April 2018**	**Good April 2018**
88 Travis Gardens	**Good April 2018**	**Good April 2018**	**Outstanding April 2018**	**Good April 2018**	**Good April 2018**	**Good April 2018**
Danescourt	**Good Jan 2018**	**Good Jan 2018**	**Good Jan 2018**	**Good Jan 2018**	**Good Jan 2018**	**Good Jan 2018**
2 Jubilee Close	**Good Aug 2019**	**Good Aug 2019**	**Good Aug 2019**	**Good Aug 2019**	**Good Aug 2019**	**Good Aug 2019**

Internal Audit Reports

During 2022/23, 360 Assurance (the Trust's Internal Audit service) has reported the following three Internal Audits to Audit Committee relating to quality:

Table 6:

Audit	Received	Audit Opinion
Clinical Effectiveness	May 2022	• Significant Assurance
Clinical Policies	February 2023	• Significant Assurance
Safe Staffing	February 2023	• Limited Assurance

Significant Assurance - As a result of this audit engagement we have concluded that, except for the specific weaknesses identified by our audit in the areas examined, the risk management activities and controls are suitably designed, and were operating with sufficient effectiveness, to provide reasonable assurance that the control environment was effectively managed during the period under review.

Limited Assurance - As a result of this audit engagement we have concluded that, in the areas examined, the risk management activities and controls are not suitably designed, or were not operating with sufficient effectiveness, to provide reasonable assurance that the control environment was effectively managed during the period under review.

The following arrangements are in place for all Internal Audit (360 Assurance) reports to provide internal assurance:

- The audits are reported through the Trust's governance structures i.e., Quality Committee, Finance, Performance and Informatics Committee, People and Organisational Development Committee and Audit Committee.
- There is an action plan in place for each audit where recommendations have been made from the audit results. These action plans have a responsible Executive Director and agreed time scales for completion.
- A process for monitoring and follow up of all audit actions is in place with actions leads and through the scheduled meetings with the Executive Directors.

2.2 Statements of assurance from the Board

2.2.1 Freedom to Speak Up (FTSU)

As a Trust we have undertaken a significant amount of work to embed measures which enable and empower staff to speak up about issues that concern them, considering equality, diversity and inclusion. Work led by the Freedom to Speak Up (FTSU) guardian team over the last 6 years has focussed on developing partnerships with front line staff, managers, board members and other partner organisations, with a view to enhance patient safety and staff wellbeing through a strong FTSU culture.

The Trust has established several routes that staff can take to speak up about issues that concern them which have been adapted over the last year to accommodate remote working. We used digital routes through which staff can raise issues via Microsoft Teams and Zoom, and continued to support face to face meetings where social distancing and infection prevention measures could be used. There are established routes where staff can raise concerns by speaking up to line managers and clinical leads and, where this is not possible, staff can raise with the FTSU team, staff-side representatives, safeguarding team, spiritual support and the health, wellbeing, and security support team. There is also an option to anonymously 'speak up' using a button on the staff intranet or they can contact a FTSU Champion via text, email, or contact through social media. This collective approach has been critical in offering a diverse range of opportunities for staff to raise issues and ensure that they are offered support during the pandemic.

In 2022/23, the Trust received 59 FTSU concerns. Concerns raised are shared appropriately and confidentially with relevant teams or members of staff swiftly to ensure proportionate rapid action is taken and the concerns are then triangulated with other sources of information to provide a comprehensive overview of the specific area, which can inform further action. The FTSU Guardian Team ensure that support is provided to individuals and teams to ensure that the concern raised is addressed satisfactorily to all parties. We continue to seek feedback from those that have raised concerns in order to improve. The feedback we have received demonstrates that people in the Trust have a very positive experience of speaking up and we perform well in respect to national comparators. Specific work has been conducted over the past year to improve FTSU culture, specifically concerning visible leadership. The FTSU Guardian came into post in November 2022 and has been involved in cultural improvement, visible at staff networks and attending team meetings and events across the Trust. Since starting in the role, the Guardian has made an increased effort to be a visible presence throughout the Trust, regularly attending frontline services while at the same time increasing the amount of FTSU champions based throughout the Trust.

Throughout the last 12 months, we have continued to grow our FTSU Champions from across all core services. We currently have 34 trained FTSU Champions with another 29 awaiting completion of their training in July 2023. We are still recruiting more to cover areas across the

organisation where reporting is low or non-existent. FTSU Training provided the champions with tools and skills to have conversations to encourage civility and respect amongst colleagues. Work is being undertaken by the Guardian and the Improvement and Culture Team around civility and respect and some training packages are being piloted in clinical areas with a view to rolling this out through the Trust. The Trust supports the message that "speaking up" encompasses matters that might be referred to as 'raising concerns', 'complaining', 'raising a grievance' 'raising concerns about bullying' or 'whistleblowing'.

Safety Huddles have successfully been implemented across the Trust. The feedback from staff is that the Safety Huddles have improved communication whilst maintaining consistency and keeping patients and staff safe. Huddles are designed to promote a 'Just Culture' and are short multidisciplinary briefings, including support staff, held at a pre-arranged time and place, and focus on the patients most at risk. Effective Safety Huddles involve agreed actions, are informed by visual feedback of data, and provide the opportunity to celebrate success in reducing harm. The organisation has been awarded a certificate to recognise the successful implementation of Safety Huddles in a Mental Health, Learning Disabilities and Community Foundation Trust.

Board of Directors
The Board of Directors will be undertaking a review of the Freedom to Speak Up process using the FTSU reflective planning tool. This work will be taken alongside the review of the FTSU policy which needs to reflect the instruction from the National Guardians Office (NGO) around the national Speak Up policy. This self-assessment will be coproduced using the guidance published by the NGO and focusses upon positive practice and areas for development. Board engagement sessions will also be utilised to further educate board members of best practise for FTSU.

Freedom to Speak Up – Progress
We updated our internet and intranet pages to include the updated Whistleblowing Policy after amendments were made to reflect the new Director of People and Organisational Development, who is the Executive Sponsor for FTSU in the organisation.

A Freedom to Speak Up e-learning package, in association with Health Education England is available for all staff on the Electronic Record System (ESR). This is a modular course with 3 levels, depending on the level of staff in the Trust, including executive and non-executive directors, lay members and governors.

FTSU continues to be embedded within our culture and we are currently reviewing our overall approach to Restorative, Just and Learning Culture in line with the adoption of the Patient Safety Incident Response Framework. This review will inform our next steps and our approach to civility and respect within the organisation. Twenty-six individuals from a cross section of the organisation completed the Mersey Care Just Culture Program, with participants set to become Civility Leads and help with implementation of Just Culture within the organisation. The Guardian has also completed the Just Culture Program which will further enable this cultural change within the origination.

After review of a case study by the NGO, work is being undertaken by the Guardian to develop a FTSU managers handbook and contact has been made with a regional FTSU guardian who initially developed the handbook. This should again help to further imbed FTSU and give managers a practical guide on how to deal with concerns should they arise.

In the past 12 months we have enhanced our focussed upon embedding FTSU into organisational culture by:

- Provided new starters, including International Nurse Recruits and students, with information packs on FTSU.

- Opportunity to be part of a steering group on how to tackle racism, how staff can be supported in reporting these cases and what support can be given to them.
- FTSU targeted induction sessions delivered for vulnerable groups such as junior doctors, students, international recruits and new starters.
- Civility and respect training packages to be piloted in 2023 with a view for this to be rolled out throughout the trust.
- Increased visible presence of the Guardian in clinical areas with the aim of increasing engagement with FTSU and attempting to break down the barriers to people speaking up.
- The Guardian attends diversity networks, where people who may find it challenging to speak up and may be more susceptible to be excluded can 'speak up'.
- The Trust has continued to host 'cultural conversations' virtually. These are open to all staff to enable open improvement conversations, the "Ask Me Anything" sessions on Freedom to speak up held with good attendance from throughout the Trust.
- Work being undertaken to create a 'you said we did' on the staff intranet page in order to further promote a speaking up culture and share the positive outcomes around speaking up.

Adopting and implementing FTSU in this way has yielded several benefits for patients, staff, and joint working. Key achievements over 2022/23 have been:

1. Focussed work between the Patient Safety Team and the Improvement Team on the importance of early reporting incidents and the implementation of Safety Huddles which has led to an improvement in earlier incident reporting concerning patient safety.
2. Demonstrating year on year improvement with regards to the NHS staff survey ratings regarding the questions that contribute to the FTSU agenda.
3. Facilitating Leadership Support Circles which support staff with psychological wellbeing and have been vital during the last year.
4. Connecting and meeting with other neighbouring Trust leads on FTSU has enabled learning and good practice to be shared and processes embedded to systematically improve patient care internally and with our external colleagues.
5. Guardian meetings and peer support has been enhanced and informal education sessions and skills sharing has been undertaken to develop and share good practice with our partners.
6. Introducing and planning the next stage of Restorative Just Culture at the Trust, collaborating with several stakeholders in the organisation on the next steps and how best to sustain this approach. We will continue to link in with the national Community of Practice that has been set up by Mersey Care and sharing learning from other organisations.

2.2.2 Community services for adults and children

The recovery phase of the pandemic in 2022/23 has continued to bring both planning and operational pressures across our services. Despite this, we have continued to develop and improve our community services across the Trust. Key investment into staffing in community services in 2022/23 was as follows:

Doncaster Mental Health (Adults and Older People)	
Enhanced Care Home – LD Services	£25,296
MH Inpatient Discharge	£492,712
Eating Disorder Investment	£58,865
Perinatal Investment	£215,135
Transfer of Perinatal funding from SHSCT (Sheffield Health and Social Care NHS Trust)	£225,310
Talking Therapies (IAPT)	£130,362

Doncaster Physical Health

Virtual Ward	£140,473
Ageing Well	£472,615
Woodfield 24 (End of Life)	£128,000
Transfer of Intermediate Care investment from DBHFT (Doncaster and Bassetlaw Hospitals NHS Foundation Trust)	£255,423

Doncaster Childrens

Mental Health Support Teams	£237,095
CAMHS LD Speak Up Service	£10,553

Rotherham Mental Health (Adults and Older People)

Perinatal funding transfer from SHSCT	£221,914
Perinatal (21/22 Full Year Earnings - FYE	£159,820
Early Intervention in Psychosis	£51,000
Additional Roles Reimbursement Scheme (21/22 FYE)	£77,024
CMHT Transformation (21/22 FYE)	£86,402
Safer Neighbourhoods	£61,677
Memory Services	£123,000

Rotherham Childrens

CYP Eating Disorders	£206,807
Mental Health Support Teams	£259,500
CYP Community and Crisis Services	£57,016
Neurodevelopment Service	£470,324

North Lincs Mental Health (Adults and Older People)

CMHT Transformation	£250,247
CMHT Transformation 21/22 FYE	£179,753
S136 Suite	£236,365

North Lincs Childrens

Mental Health Support Teams	£353,079

- **Community Mental Health Transformation**

In 2022/23 we embarked on year two of a three-year Community Mental Health Transformation Programme and started our Crisis Transformation Journey.

The community transformation programme has redesigned integrated models of primary and community mental health care across Rotherham, Doncaster and North Lincolnshire supporting adults and older adults with severe mental illnesses. Three new community-based offers coproduced at PLACE includes access to psychological therapies, improved physical health care, employment support, personalised and trauma-informed care. This includes maintaining and developing new services for people who have the most complex needs and proactive work to address racial disparities tackling health inequalities. Local areas have supported the redesign and reorganisation of core community mental health teams to move towards a new place-based, multidisciplinary service across health and social care aligned with primary care networks.

The Community Mental Health Transformation enters its third year with significant investment in expanding the primary care workforce, since 20/21 the mental health workforce has grown with a total of 52 new posts, aimed at heavily supporting the ‘Right care, Right time, First time’ approach to mental health and emphasising ‘No Wrong Door’. The roles include therapeutic, clinical and non-clinical roles working in partnership with primary care.

The CPA alternative programme began in 22/23 and will continue in 23/24 starting with a roll out across all primary care hubs and early intervention services with a focus on the whole system mobilising the new approach throughout 24/25.

We have further invested in our VCSE partners and developed roles with a focus on co-production and peer support, emphasising the need to codesign our new models of care with service users and carers, lead by a new expert by experience working centrally on behalf of all three care groups.

- **Doncaster Physical Health services**

In 2022/2023 Doncaster Physical health services received funding to develop Home First services in the community. This included increasing our capacity within our Urgent Community Response service to expand referrals and meet the two hour response targets. During February and March 2023, the response was that 95.85% of people were seen within two hours of referral. This development will continue into 2023/2024 with further referral routes developed and matrix working across Home First services embedded.

The Virtual Ward has started to be developed in partnership with our Acute partners. The vision is an integrated Virtual Ward into other community services that will accept both step up and step down patients. This will continue to develop and expand into 2023/2024.

The way that we support people in care homes proactively received enhancements during 2023/2024 with a pathway funded for people with Continuing Healthcare status who were admitted into an assessment bed. A proactive package of assessment and care is now implemented to enable people to either remain appropriately in the care home or be supported to return to their own home following recuperation and rehabilitation. This was developed alongside the Enhanced Care Home Team which was expanded to proactively support care home residents with both physical and mental health needs to remain in the care home to have their needs met. This involves working alongside care home providers to change their routes of escalation, pre-emptive care planning and providing education and support to staff. This will be further developed during 2023/2024.

- **Childrens Services**

The Children's Care Group have implemented and mobilised Zone 5-19 Doncaster Children and Young People's Health and Wellbeing Service; this new service combines all the elements of school nursing together with a service that promotes positive lifestyle choices, providing advice and support on the impacts of alcohol, drugs, smoking, sexual health, and contraception. This model of practice has been recognised nationally as good practice.

Throughout 2022/23 we have recruited to implement a robust CAMHS Crisis and Intensive Community Support Team model of care; once fully implemented this model of care should reduce the need for Tier 4 admission for our Children and Young People and reduce the length of stays for those admissions that are unavoidable. At the end of the 2022/23 fiscal year the team are up to the required establishment to cover 7 days, with the projection of 24 hours cover to be in place by September 2023.

The Children's Care Group launched the Virtual Reality pilot project. Young people who are referred to the pilot will be provided with virtual reality (VR) headsets to replicate real world situations, this exposure therapy will support treatment for conditions such as social anxiety, panic, and generalised anxiety.

The Care Group have rolled out ECGs in base points to support timely health investigations for our Children and Young People accessing out Eating Disorder Service and those in our Child and Adolescent Mental Health services who may be prescribed medication which requires regular cardiac function to be monitored.

Doncaster 0-5 Health Visiting service have been reaccredited as a Baby Friendly service.

Doncaster “With Me in Mind” Mental Health Support Team have been awarded “Child Friendly” service status. Rotherham With Me In Mind service has been awarded wave 9 funding and will be recruiting to this to increase school coverage in the Rotherham area. North Lincs With Me In Mind teams have 100% coverage for North Lincs primary schools.

A Nurse Consultant in Research was appointed this year to support and implement the Chief Nursing Officer strategy in increasing and aligning research into practice within our Children’s services.

Our neurodevelopment assessment pathways have successfully partnered with digital assessment providers to significantly reduce the number of Children and Young People awaiting assessment.

The community Eating Disorder service has worked tirelessly to manage the increased demand through the covid-19 pandemic, the team are meeting all required KPI’s and national access and waiting time standards.

2.2.3 Learning Disability Improvement Standards benchmarking

NHS Improvement have developed four standards that trusts need to meet; doing so identifies them as delivering high quality services for people with learning disabilities, autism or both.

The Trust is partially meeting these standards.

With regard to learning disabilities, the Trust takes part in the annual benchmarking of our learning disability services, we hold a Trust wide quality circle meeting attended by multi professionals and are part of the learning disability quality effectiveness group.

The scope of the quality circle focuses on a number of key agenda items; however these are currently under review and the 2023/24 programme will specifically focus on the four standards with a focus on one standard per quarter.

With regard to Autism, the Trust does not feel that we meet these standards due to variations in the commissioning of services across the Trust, which has an impact on what is delivered at each place. Whilst the Trust endeavours to be clear about what can currently be offered to people with Autism, we feel that there is more that can be done before the Trust is fully able to meet these standards.

The four standards concern:

1. **Respecting and protecting rights**
   Annette’s charter remains a live document across the trust. This is reviewed regularly through the learning disability quality circle and embedded in services and with new starters. Ensuring we involve families and carers at all points around a person’s life
   The trust has a monthly learning disability forum known as the Quality Circle. This is attended by a number of key professionals ensuring we have a collective voice and ensure that we are making continues service improvements for people with learning disabilities.

2. **Inclusion and engagement**
   The Doncaster Learning Disability team have a Health Co-facilitator who works a minimum of 2 days per month within the Health Action Team. They are an active member of the team and support the wider learning disability community with training, advocacy and being the voice of people with learning disabilities.

The ‘My Health, My Knowledge, My Way’ podcast and accessible series is live.

3. **Workforce**
   Learning Disability specific Trainee Nurse Associates are identified as a recruitment need or have been successfully recruited. We are currently exploring the Learning Disability Nurse Apprentice programme. Level 3, 4 or 5 Positive Behavioural Support courses are underway to ensure the existing workforce develops their skill base within this area to meet the referral demand.

4. **Specialist learning disability services**

- The Positive Behaviour Support pathway is under development.
- The Sensory pathway is being developed for the Learning Disability and/or Autism Spectrum Disorder (ASD) population.
- ADHD (Attention Deficit Hyperactivity Disorder) Learning Disability specific pathway is now implemented.
- The Allied Health Professional Team are developing a new posture pathway and OTAGO classes which involve exercises which are designed to help build up strength and improve balance in order to help prevent falls.
- Each area of the Trust holds the learning disability dynamic support register on behalf of the Integrated Care Board (ICB) this ensures we have effective and full oversight of all the people who are currently in hospital or are at risk of being admitted to a hospital. Holding the register allows us to work with our partners to avoid admission wherever possible.

The Trust is reviewing both its learning disability and its autism services against these standards and has submitted data for national benchmarking. The Trust is currently awaiting the latest benchmarking output data, the most recent output data received was in 2020/21.

A work stream is actively reviewing audits around transitions and the STOMP agenda. Further work steams have been developed to undertake targeted work in relation to training staff in the role of Learning Disability Ambassador’s and reviewing how we receive feedback, concerns and complaints and embedding “Ask Listen Do”.

2.2.4 Response to national concerns regarding the care of patients with a learning disability and/or autism

On 30 September 2022, the national Director of Mental Health wrote to all Chief Nurses and Chief Medical Officers to raise concerns about the standard of care portrayed on several national media programmes. These showed appalling care and evidence of toxic cultures, with an inability to listen to or act on the voice of the patient.

Prior to this letter, the former Chief Executive of Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) had created several sessions for open dialogue for middle managers to reflect on “could it happen here”? In addition, the Trust took part in Time to Reflect with the NHS Chief Nursing Officer and Head of Quality Transformation, Mental Health, Learning Disability and Autism (MHLDA), NHS England on 18 November 2022. This provided a baseline lead into the Trust’s inpatient quality improvement programme launched April 2023

The MHLDA inpatient Quality Improvement programme is being overseen at Integrated Care Board (ICB) level through steering groups and RDaSH is actively involved in both South Yorkshire ICB and Humber and North Yorkshire ICB. Adult and older adult inpatient services are within the scope of the project and it will be a 3 year programme starting in 2024/25.

Immediate response to the Director of Mental Health letter and longer-term actions taken by the Trust are summarised below:

- **Review of the seclusion policy**

During the final stages of the policy update, a small working group was gathered to discuss the policy in the context of the media findings. The aim was to ensure the Trust can effectively guide staff how to use the detail of the seclusion segregation policy. This was to ensure that restrictive interventions are clear in policy and can be followed easily. Some changes were made, and the final policy is now available on the Trust website.

- **Matron and service manager leadership development**

"Stepping into your authority" course has been commissioned from the Florence Nightingale Foundation starting 16th January 2023. This has been fully supported within the Trust by the Chief Operating Officer and Chief Nurse to enable care groups to free time to care for matrons and ward leaders to lead.

- **Integrated Quality Performance Review (IPQR) Dashboard**

This data will be available at the matrons' fingertips to enable them to target action, visits, and supervision. This focuses the Trust quality dashboard at the matron level showing safety, effectiveness, and patient experience of care.

- **Our Patient's Voice**

This work will be prioritised using a deputy director level post embedded in the safety and quality team. RDaSH prioritises listening to people we care for.

- **Review of advocacy on inpatient units**

A mapping exercise has taken place and this is being assessed for gaps and possible actions. The patient experience team are working on a plan to increase the number of peer volunteers available on wards as another way of hearing the patient voice.

- **Peer review visit process leading to ward accreditation**

RDaSH has established an internal peer to peer review process, based on the CQC Key Lines of Enquiry and including the "15 step challenge" and how to identify toxic cultures (based on the CQC guide). The peers include volunteers, colleagues from across RDaSH, executive and non-executive directors. This was launched in November 2022 and has now become business as usual. From May 2023 this will lead to an internal accreditation award for ward and service leaders to own.

- **Minimum safe staffing (inpatient units)**

The Trust has an ability assess how safe the inpatient unit is based on the twice daily patient flow meetings which note staff ratios, acuity and risks for the day and week ahead. An evidence based acuity and dependency tool (MHOST NHSE) has been launched to gather data to provide full insight into how RDaSH current establishments or ratios match the needs of patient care. Data gathering started 24 April 2023, for 28 days and is being led by operational teams. This will be analysed and summarised into a report via the Chief Operating Officer and Chief Nurse to Quality Committee and therefore inform the board.

2.2.5 Review of Services

During 2022/23 Rotherham Doncaster and South Humber NHS Foundation Trust provided and/or sub-contracted 54 relevant health services.

Rotherham Doncaster and South Humber NHS Foundation Trust have reviewed all the data available to them on the quality of care in all 54 of these relevant health services.

The income generated by the relevant health services reviewed in 2022/23 represents 100% of the total income generated from the provision of relevant health services by Rotherham

Doncaster and South Humber NHS Foundation Trust for 2022/23.

Further details of the services provided/sub-contracted by Rotherham Doncaster and South Humber NHS Foundation Trust are provided on Rotherham Doncaster and South Humber NHS Foundation Trust's website at: https://www.rdash.nhs.uk/services/our-services/

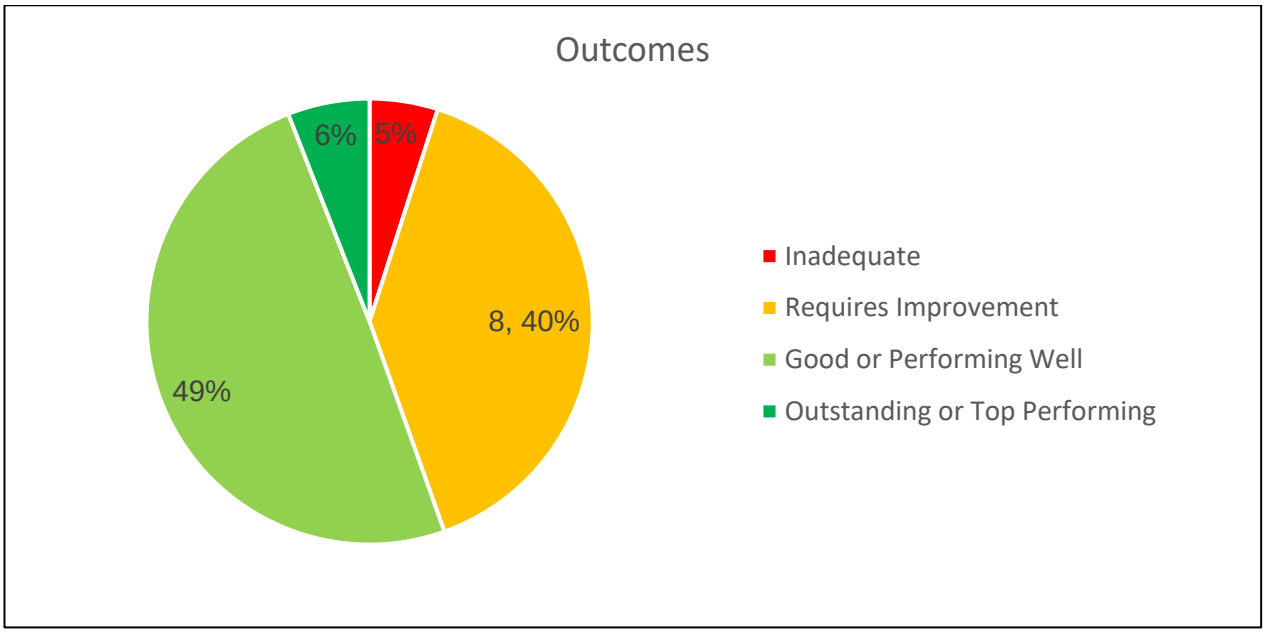
2.2.6 Clinical Audit

Trust (local) Clinical Audits

The new Audit Framework has been embedded through 2022/23 which provides the structure for clinical audit activity in the Trust. The Trustwide forward clinical audit programme for 6 key audit activity in 2023/24 is to be discussed, agreed and ratified by the designated assurance groups within the Trust by May 2023.

The reports of 22 local clinical audits were reviewed by Rotherham Doncaster and South Humber NHS Foundation Trust in 2022/23.

Of the 22 completed audits, 1 was rated Inadequate (4.5%), 8 were rated Requires Improvement (36.4%), 10 were rated Good or Performing Well (45.5%) & 3 were rated Outstanding or Top Performing (13.6%). The breakdown of outcomes was as follows:



At the end of 2022/23 the status of the audits on the Programme was as follows:

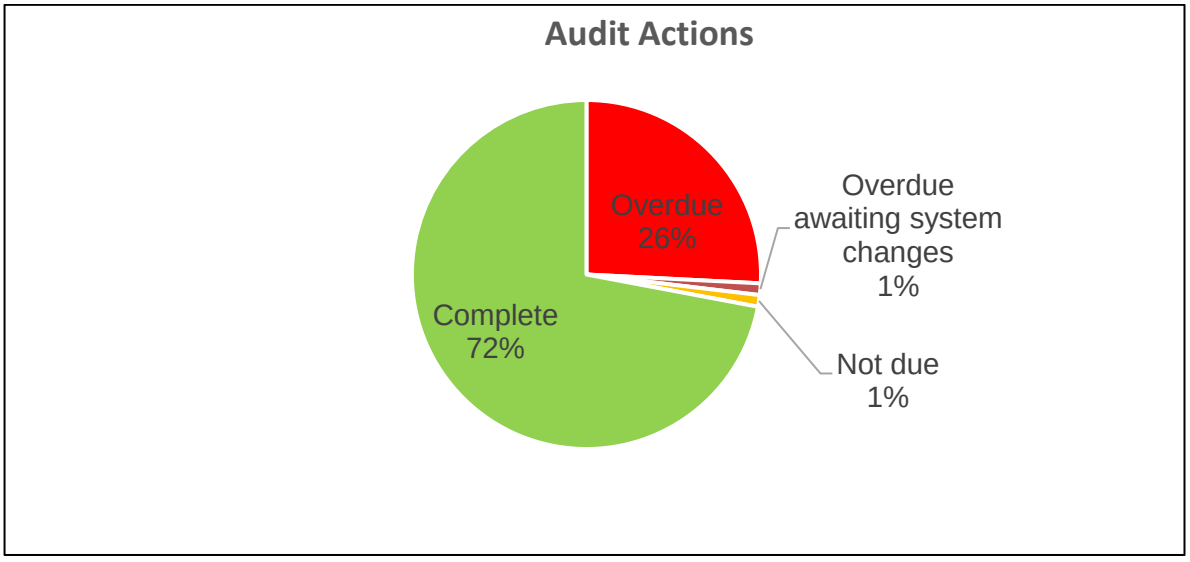
Table 7: Status of the six key Trust Clinical Audits as at end 2022/23	
Background work underway following completion of the associated NICE Quality Standard	1 (17%)
Data collection complete – analysis in progress/report being drafted	4 (66%)
Audit Complete	1 (17%)

Table 8: Status of carry overs from 2021/22 Trust Clinical Audits as at end 2022/23	
Data collection complete – analysis in progress/report being drafted	1 (17%)
Audit Complete	5 (83%)

The results of each audit are reported and analysed by the Clinical Effectiveness Team and shared through either the Care Groups Quality Meetings through their Audit Leads or the associated Trustwide assurance groups or steering groups. Action plans are developed collectively in each case and progress against these actions is tracked centrally by the Audit Team.

Audit Actions (local and national)

- 19 completed local audits had action plans developed to improve the quality of healthcare provided, generating a total of 93 actions. 68% of the agreed actions have been completed.
- 5 national audits had action plans developed to improve the quality of healthcare provided, generating a total of 11 actions. 82% of the agreed actions have been completed with 18% currently due.



The 4 remaining national clinical audits where action plans were not generated are detailed as follows:

- **National Clinical Audit of Psychosis (NCAP) Early Intervention in Psychosis (EIP)** - Case Note Audit – Action plans were produced in March 2022 following the issue of the initial results by NCAP and therefore excluded as it was prior to the 01/04/22.
- **National Audit of Dementia (NAD) - Spotlight Audit in Community Based Memory Assessment Services** –Audit leads were asked to review the report and results and where required formulate any actions to improve performance and complete the attached Recommendations and Actions template. PRECIS covering RDaSH prescribing aspects was presented at the November 2022 MMC meeting.
- **National Audit of Inpatient Falls (NAIF)** - 2021 Clinical Data & 2022 Facilities Audit – There were no reported instances during 2021 of RDaSH patients suffering a fall that led to a femoral fracture reported by acute Trusts on the National Hip Fracture Database (NHFD)
- **National - Sentinel Stroke National Audit Programme (SSNAP) Report** - By combining comprehensive information about the composition and quality of stroke services both at a team/hospital level and at a patient level, SSNAP provides a powerful tool for clinicians, managers, health boards and commissioners and the public to evaluate performance in stroke care, identify further needs and drive the process of continuous quality improvement.

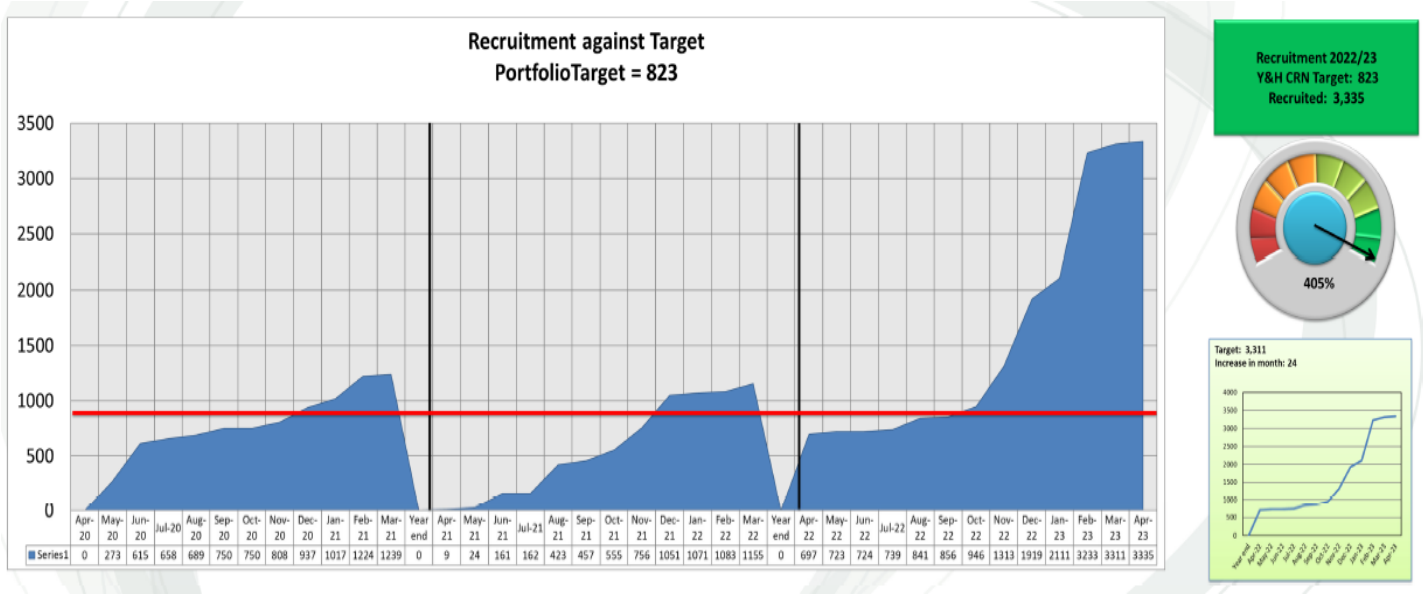
The Trust Clinical Effectiveness Lead can be contacted in relation to clinical audit reports, local and national (where available) and local activity linked to the responsive rolling programme based on care group or service priorities.

As the Trust moves to adopt the National Patient Safety Incident Response Framework (PSIRF) this may influence the clinical audit activity and systems and processes that support these. There is collaborative engagement between the Clinical Effectiveness Team and the groups and individuals leading on this work.

2.2.7 Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Rotherham Doncaster and South Humber NHS Foundation Trust in 2022/23 that were recruited during that period to participate in research approved by a research ethics committee and on the National Institute of Health Research (NIHR) portfolio was 3311 against an increased target of 823 participants in the NIHR portfolio studies.

RDaSH NHS Foundation Trust actual recruitment against target for 2022/2023 and comparison of 2022/23 performance with previous two years



Based on recruitment performance, the Trust's research team, Grounded Research (GR), were ranked as the highest performing research team out of the mental health and community Trusts in Yorkshire and Humber. They were the eighth highest recruiting overall, and when performance was ranked based on complexity of the research (ABF category), RDaSH were the third highest recruiting Trust in the region. The research studies conducted within RDaSH spanned the disciplines of mental health, nutrition, community public health and occupational wellbeing.

Yorkshire and Humber recruitment performance based on complexity weighting [RDaSH ranked third in the region]

LCRN Recruitment by ABF Category
ABF Year: Apr 2022 to Mar 2023

TrustName	Large Observational	Observational	Large Interventional	Interventional	Commercial	Total Recruitment	Total Weighted Recruitment
Total						**115,903**	**378340.72**
Leeds Teachi...	2,757	6,206	8,460	2,773	955	21,151	84478.58
NIHR CRN: Yo...	7,256	810	13,505	2,281	146	23,998	52257
Rotherham D...	**110**	**56**	**0**	**3,189**	**0**	**3,355**	35385
Sheffield Teac...	194	4,346	399	1,654	419	7,012	35207.19
Bradford Teac...	8,824	673	1,717	1,210	292	12,716	31372.2
Non-NHS Activ...	18,184	1,848	0	189	0	20,221	26731
Doncaster and...	871	183	71	2,160	10	3,295	25795.2
Hull University...	4,541	985	242	1,230	262	7,260	23610.5
York and Scar...	841	2,233	169	465	115	3,823	14094.55
Mid Yorkshire...	1,184	685	463	354	38	2,724	8289.32
Calderdale and...	406	369	761	175	13	1,724	6123.86
Yorkshire Am...	0	318	0	398	0	716	5491
Sheffield Child...	83	578	0	193	91	945	4229
Leeds Comm...	0	594	0	79	0	673	2948
Harrogate and...	698	341	171	60	6	1,276	2882.5
Leeds and York...	72	99	0	223	0	394	2871.5
Bradford Distri...	20	366	0	132	0	518	2753
Airedale NHS...	139	272	66	49	2	528	2580.32
Humber Teach...	37	277	275	87	0	676	2238.5
The Rotherh...	245	234	53	95	0	627	2162
Northern Linco...	756	92	131	53	23	1,055	2142
South West Yo...	43	192	0	123	0	358	2068
Sheffield Heal...	40	194	0	61	3	298	1390
Barnsley Hosp...	203	141	78	26	57	505	1060.5
CCGs	32	14	1	8	0	55	180

The team is based in a fully functioning, dedicated community Clinical Research Facility (CRF), within the existing NHS Trust infrastructure. The facility comprises clinical areas, bespoke pharmacy (for dispensing clinical trial medication) and a dedicated laboratory (to process research bio-samples). It was set up with support from the Yorkshire and Humber Clinical Research Network (CRN) to respond to the research needs of the COVID-19 pandemic. The CRF was designed with input from all parts of the local community and within weeks of opening the Team operated national and international vaccine trials. The GR team were named Research Team of the Year for 2022 by the National Institute for Health and Care Research (NIHR) Clinical Research Network, Yorkshire and Humber and were nominated for the Nursing Times Awards Clinical Research Nursing category in 2022 for this work.

GR has successfully engaged commercial research companies with trials starting imminently. This has included a new UK-Israel collaboration to bring innovative mental health treatment solutions to the NHS in the UK, through Israeli company Taliaz's Artificial Intelligence (AI) software platform PREDICTIX, that offers clinical decision support tools and patient management for psychiatrists and GPs. Taliaz is the first company to move forward rapidly in the UK as a result of GR participation in a delegation from the Northern Health Science Alliance (NHSA) to BioMed Israel in 2022. Due to open in 2023, GR are currently setting up 2 pharmaceutical company sponsored clinical trials to test the effectiveness of new drugs in

schizophrenia and COVID-19.

In collaboration with the Northern Health Science Alliance (NHSA) GR has launched Phase 1 of the Northern Innovation Accelerator for Mental Health (NIAMH). The Accelerator is designed to spearhead innovation in mental health research that is clinically led and academically supported for industry. It aims to supercharge mental health innovation with urgency, for speedier advances to address the UK's pressing mental health needs at scale.

GR has sponsored, led and delivered on several national NIHR funded studies. The Fresh Street trial tested the efficacy on key health outcomes of providing £5 vouchers for fruit and vegetables to randomly selected streets in Doncaster. GR engaged with over 800 households, delivering the vouchers on a weekly basis for a period of six months. The Physical and Mental Health of Older Prisoners (PAMHOP) study was conducted in conjunction with the University of York, in several prisons across Yorkshire and the Humber. This study engaged 70 participants to develop a toolkit of interventions to improve the health of prisoners nationally. The IGLOo trial is designed to understand the support employees receive during their long-term sick leave and in their return to work and involves numerous NHS sites (including RDaSH) and non-NHS organisations. In 2023 the GR team in partnership with the University of Sheffield will begin the set-up of the StratCare-2 trial, which will evaluate the clinical and cost-effectiveness of AI-driven stratified care for depression.

Every year, the NIHR Clinical Research Network asks thousands of research participants to share their experiences of taking part in research. The Participant in Research Experience Survey (PRES) aims to put participant experience at the heart of research delivery - helping to improve the way research studies are designed and delivered, now and in the future. GR have collected PRES in all of its studies, gathering 88 responses against a target of 32. The information received brought to light many positives from various participants, as well as suggestions on how to improve experiences for those wanting to participate in research in the future.

At the end of the year RDaSH became the first NHS Trust to achieve the Workforce Quality Accreditation Gold Standard awarded by the International Accrediting Organisation for Clinical Research (IAOCR). This accreditation focuses on employer best practises in the areas of employee engagement, competence and mental health and wellbeing and will help secure site-selection for RDaSH in further commercially funded research.

2.2.8 Commissioning for Quality and Innovation (CQUIN)

The CQUIN scheme this year includes core clinical priority areas, where improvement is expected across 2022/23. NHS England and NHS Improvement have suggested that the indicators focus on specific evidence-based improvements, rather than on complicated change programmes. The CQUINs are nationally set at the beginning of the financial year for us to develop and work towards improving quality across services throughout the 12 months. The Trust is required to ensure all reasonable endeavours are made to achieve the CQUIN Scheme for 2022/23 to drive improvements in the areas identified with the aim of improving the quality of the NHS services and outcomes for patients.

This scheme sets out 15 national CQUINs, eight of which CQUINs are applicable to Rotherham Doncaster and South Humber NHS Foundation Trust:

Table 9:

Ref	CQUIN Indicator	Target
CCG1	Flu Vaccinations for frontline healthcare workers	70% - 90%
CCG9	Cirrhosis and fibrosis tests for alcohol dependent patients	20% - 35%
CCG10	a) Routine outcome monitoring in CYP and perinatal mental health services	10% - 40%

	b) Routine outcome monitoring in community mental health services	10% - 40%
CCG11	Use of anxiety disorder specific measures in IAPT	55% - 60%
CCG12	Biopsychosocial assessments by MH liaison services	60% - 80%
CCG13	Malnutrition Screening	50% - 70%
CCG14	Assessment, diagnosis and treatment of lower leg wounds	25% - 50%
CCG15	Assessment and documentation of pressure ulcer risk	40% - 60%

Further details of the National CQUIN Schemes for 2022/23 are available electronically via the NHS England web page at https://www.england.nhs.uk/nhs-standard-contract/cquin/2022-23-cquin/

2.2.9 Care Quality Commission (CQC) Registration

Rotherham Doncaster and South Humber NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is for the following regulated activities:

- Accommodation for persons who require nursing or personal care
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Family planning
- Personal care
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder, or injury

With regards to Rotherham Doncaster and South Humber NHS Foundation Trust's CQC registration, during 2021/21 reporting period:

- No enforcement action was taken by CQC against Rotherham Doncaster and South Humber NHS Foundation Trust.
- Rotherham Doncaster and South Humber NHS Foundation Trust have not participated in any special reviews or investigations by the CQC during the reporting period.

Rotherham Doncaster and South Humber NHS Foundation Trust has the following conditions on registration, applied against the 'Accommodation for persons who require nursing or personal care' activity:

1. The Registered Provider must not treat persons under eighteen years of age at the location Danescourt.
2. The registered provider may not use the enhanced care accommodation at Danescourt.
3. The Registered Provider must only accommodate a maximum of 5 service users at Danescourt.

2.2.10 Data Quality

Hospital Episode Statistics

Rotherham Doncaster and South Humber NHS Foundation Trust submitted records during 2022/23 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- Which included the patient's valid NHS number was 100% for admitted patient care (not applicable for outpatient care and for accident and emergency care).
- Which included the patient's valid General Medical Practice Code was 100% for admitted

patient care (not applicable for outpatient care and for accident and emergency care).

Data Security

The national NHS Digital Data Security and Protection Toolkit reports whether standards '*have*' or '*have not'* been met from NHS Provider submissions. Rotherham Doncaster and South Humber NHS Foundation Trust achieved 'Standards Met' for 2021/22 and expect to achieve 'Standard Met' for the 2022/23 final submission in June 2023.

Payment by Results

Rotherham Doncaster and South Humber NHS Foundation Trust is paid on a block basis for the services it delivers and is therefore not subject to any Payment by Results coding reporting.

Data Quality

Data quality and accuracy is governed through the Trust's annual Data Quality Improvement programme, reporting a quarterly position to the Finance, Performance and Informatics Committee on progress and position. This programme provides key focus on measures linked to NHS Oversight Framework and quality related Board Assurance Framework risks, whilst also supporting wider data quality discussion.

The Trust Head of Information Quality / Clinical Safety Officer provides clinical leadership to translate and drive data quality needs into improved clinical recording accuracy and practice, whilst also understanding needs for improved quality of care delivery and efficiency.

Subject to both internal and external validation, the Trust is committed to continuously improving the Board Assurance Framework position for data quality and related quality of care outcomes.

The quality of our services will continue to be increasingly defined at an operational level through care groups, with service user, carer and stakeholder involvement, with due regard to appropriate organisational governance arrangements and oversight by the Board of Directors.

There is an approved Clinical Audit Policy which describes the Trust's approach and arrangements and an approved clinical audit programme. The clinical audit function is used appropriately to focus on risks, as well as on nationally identified issues. Progress against the clinical audit programme and the outcomes of audits are reported to the care groups.

The Trust Data Quality Policy provides assurance on the approach to data quality as a Trust, aligning to the Trust information governance & management framework, national data standards and legal commitments & obligations. The policy and framework drive a clear directive for Trust wide data quality ownership, accountability, and action to ensure continuous data quality, whilst recognising the importance of accuracy for patient care and safety.

2.2.11 Learning from deaths

The Trust Learning from Deaths: the right thing to do policy sets out the Trust's expectation on how it processes, responds to, and learns from deaths of patients where we are the main provider of care to that person. There is no national guidance as to what constitutes a 'death within scope' in a Trust's activities. It is something to be determined by an individual organisation. The Trust has specific guidance within the policy to determine what is a 'death within scope'. The Trust continues to consider on a case-by-case basis if an out-of-scope death requires further review.

Within the Trust, all deaths of patients who have a learning disability are highlighted and automatically subjected to at least a Structured Judgement Review as well as scrutiny from the national LeDeR process.

The Trust has a Mortality Surveillance Group (MSG) in place which is chaired by the Executive Medical Director, and this meets monthly. In line with the terms or reference, the group has oversight of all Trust deaths including all expected and unexpected deaths, homicides/domestic homicides of patients currently in receipt of Trust care and receives information relating to any child deaths.

The Trust has a Mortality Operational Group (MOG) in line with the requirements from the Learning from Deaths policy. The group is chaired by a Consultant Psychiatrist and meets on a weekly basis with additional meetings held as and when required to ensure that reported deaths are considered in a timely manner. The aim of the group is to review the mortality information of all deaths that have occurred within the organisation that are 'within scope', determine if a Structured Judgement Review (SJR) is required or not and to escalate any deaths to the Patient Safety team where concerns are identified and where a Serious Incident investigation may be required.

All deaths are reported onto a dedicated mortality module within the Ulysses Safeguard reporting system. The module has several components including the template for the completion of SJRs and ensures that all Mortality processes are within a single system.

The Structured Judgement Reviews for deaths are conducted by trained reviewers who have undergone formal training to undertake the reviews and are senior clinicians within the organisation.

The Learning from Deaths Policy reflects current practice and has associated Key Performance indicators that are reported to the MSG. Terms of reference of monitoring groups are in place.

Mortality Data

During 2022/23 there were 704 deaths reported on the Rotherham, Doncaster, and South Humber NHS Foundation Trust mortality Ulysses system. This is down by 34 compared to 2021/22

This figure relates to deaths of patients from 1 April 2022 to 31 March 2023 who had contact with the Trust within 6 months prior to death.

Of the 704 deaths the following occurred per quarter of that reporting period:

- 169 in quarter 1 (April to June 2021)
- 139 in quarter 2 (July to September 2021)
- 219 in quarter 3 (October to December 2021)
- 177 in quarter 4 (January to March 2022)

Of the 704 deaths, 33 were deaths where Covid 19 was a causal or contributory factor.

The Trust works with eight other mental health trusts in the North of England Alliance. Since the introduction of the new mortality reporting process, the Trust has been reporting numbers of deaths which are in line with our partner organisations.

Table 10: SJRs and SI reviews undertaken 2022/23

Quarter	No of deaths	No of deaths reviewed in MOG	No of SJRs indicated from deaths that occurred in the month
Quarter 1	169	169	20
Quarter 2	139	139	26
Quarter 3	219	219	28
Quarter 4	177	177	28
Total	**704**	**704**	**102**

Of all deaths reviewed in MOG, 14% were subjected to structured judgment review.

Understanding the data around the deaths of our service users is a vital part of our commitment to learning from all deaths. For deaths resulting in reviews, the Trust seeks to identify if the death was due to a problem in care. The process also seeks to identify where a high standard of care was delivered and if there were areas of learning.

From the Structured Judgement Reviews completed to date, no deaths have been found to be due to a problem in care.

The structured judgement reviews undertaken have identified the following areas of good practice:

- Good communication between agencies
- Good physical health monitoring
- Good family engagement
- Thorough risk assessments
- Responsive care
- Comprehensive mental health examinations carried out
- Supportive care and good care plans
- Evidence of wrap around care

The Structured Judgment reviews also identified areas of learning for the Trust:

- The need to ensure that record keeping is of the required detail and is updated
- Monitoring weight if there are signs of weight loss
- Lack of monitoring in required timeframes in OPMHS
- FACE risk assessment completion was not robust at tines
- Management of patients on CTO living in another locality with no evidence of consideration of transfer to local mental health service.
- Management of patients on Clozapine in general hospitals

Learning from Inquests:

- The management of Polydypsia – this led to the circulation of national data and a brief local guide
- Fluid balance monitoring – this was fed into the task and finish groups for fluid balance and hydration
- All new Home Treatment teams referrals will be seen by a band 6 for first contact
- Home Treatment teams are now using a SOMRAP model for record keeping.
- Record keeping was referred to in a number of reviews.
- There is a need for communication with GP in very complex cases where patient requires support to get physical needs met independently - balance of optimising independence and efficient access to relevant services

As part of the work of the Mortality Surveillance Group during 2021/22, the Trust has:

- Undertaken several deep dives and reviews including an Annual review of Drug and Alcohol related deaths in Doncaster.
- Further work is ongoing in partnership with Doncaster Public health looking at deaths of people were homeless,
- Undertaken a review of several deaths in Older People's and undertook a comparison across the trust footprint. This looked at a range of demographics and compared to data from the Office of National statistics.
- Development of a relationship guide which has been circulated to ICB and place suicide prevention groups for wider use.
- Development of a new condolences letter to show compassion and care
- Learning from other organisations

The Mortality Surveillance Group will undertake the following areas of work in 2021/22:

- Further work on ensuring feedback from structured judgement reviews is being provided to clinical teams to ensure local action as needed
- Structured Judgment reviews (SJRs) are ongoing for
- learning Disability deaths. The SJR's will include a review against the key findings of the LeDer and LD Covid deaths including the management of dysphagia, access to healthcare at the right place at the right time and interagency communication. Once completed the learning will be summarised in a wider report and will be submitted to the Mortality Surveillance Group and the LD Quality Circle for further review and consideration.
- Place based reviews will be undertaken to allow further learning within the localities.

2.3 Reporting Against Core Indicators

The Trust is required to provide performance data against a core set of indicators using data made available to the Trust by NHS Digital. Guidance from NHS England specifies the following indicators must be reported on in trust quality accounts (https://www.england.nhs.uk/financial-accounting-and-reporting/quality-accounts-faqs/#what-indicators-must-be-included-in-quality-accounts).

Table 11: The percentage of patients receiving a follow up within 72 hours of discharge

The percentage of patients receiving a follow up within 72 hours of discharge – Target 60% for 2022/23			
Indicator	**2020/21**	**2021/22**	**2022/23**
RDaSH	94%	97%	97%
This indicator is not included within the NHS Digital MH Community Teams activity submission and therefore not part of national comparable data. The Rotherham Doncaster and South Humber NHS Foundation Trust considers that this data is as described and has taken the following actions to improve the quality of the data against these indicators, and so the quality of its services, in the forthcoming year (2022/2023) • Regular checks of the raw data for accuracy (prior to submission) are carried out by the Trust's Performance Team.			

Table 12: The number of patients aged i) 0- 15 and ii) 16 or over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.

Indicator	RDaSH 2019/20	RDaSH 2020/21	RDaSH 2021/22	RDaSH 2022/23
Number of patients readmitted to hospital within 28 days of being discharged aged 0-15	0	0	0	0
Number of patients readmitted to hospital within 28 days of being discharged aged 16 and over	92	50	36	79

This indicator is not included within the NHS Digital MH Community Teams activity submission and therefore not part of national comparable data.

The Rotherham Doncaster and South Humber NHS Foundation Trust considers that this data is as described and has taken the following actions to improve the quality of the data against these indicators, and so the quality of its services, in the forthcoming year (2022/2023):):
Regular checks of the raw data for accuracy (prior to submission) are carried out by the Trust's Performance Team.

Table 13: The Trust's 'Patient experience of community mental health services' indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.

Indicator	Trust 2019 Score	Trust 2020 Score	Trust 2021 Score	Trust 2022 Score	Average Trust Score England 2022
In the last 12 months do you feel you have seen NHS mental health services often enough for your needs?	64%	65%	60%	61%	40%
Were you involved as much as you wanted to be in agreeing what care you will receive?	72%	78.3	85%	78%	55%
Were the person or people you have seen most recently aware of your treatment history?	72%	75.7	71%	71%	48%

Source: CQC Mental Health Community Services Survey 2022 (https://nhssurveys.org/all-files/05-community-mental-health/05-benchmarks-reports/2022/)

The Mental Health Community Survey is an independently administered national survey of patients receiving mental health care in community settings. The survey is comprehensive and provides valuable quantitative data to facilitate comparison with other Trusts and benchmark our services numerically against a range of indicators. The survey for RDaSH in 2022 contacted 1250 service users, of which 245 completed the survey.

The results for specific questions are categorised depending on whether they are 'better', 'worse' or 'about the same' compared with other trusts. For RDaSH the breakdown was as follows:

- In 28 questions, RDaSH was 'About the Same'
- In 1 question, RDaSH was 'Better than Expected'
- In 1 question, RDaSH was 'Somewhat Better than Expected'

The overall patient satisfaction outcomes saw 26% of patients score their experience with RDaSH as 10 (out of 10), compared with a national average of 19%.

In 9 categories, RDaSH were in the top 20% of Trusts. These categories suggest that patients overall felt:

- listened to, trusted and respected
- included in decision-making about their care
- well-informed in terms of medication
- supported to get the help they needed

Only one score was in the bottom 20% of Trusts, which was "*Do you know how to contact this person if you have a concern about your care*?" While this marks a decline from 2021, where no scores went below this threshold, it should be interpreted in the context of a score (93.6%) and a lower threshold (94.9%) that are both upwards of 90%.

Table 14: The number and rate of patient safety incidents (PSI) reported within the Trust during the reporting period and the number and percentage of such PSI that resulted in severe harm or death.

Year/period	Total number RDASH PSI	RDASH rate per 1000 bed days	All MH Trusts rate per 1000 bed days	RDASH PSI Resulting in severe harm		All MHS trusts - Range resulting in severe harm	RDASH PSI Resulting in death		All MH trusts - Range resulting in death
				Num.	%		Num.	%	
2022/23									
	5320 ***local data***	N/A		3	0.05 %	N/A	38	0.07 %	N/A
2021/22									
Apr 21 – Mar 22	5194	62.7	*	3	0.1%	0%-0.4%	44	0.8%	0%-0.6%
2020/21									
Apr 20 – Mar 21	4006	48.4	*	0	0%	0% - 0.4%*	8	0.2%	0%- 0.7%
2019/20									
Apr 19 – Sept 19	2516	49.2	*	3	0.1%	0% - 2.3%	27	1.1%	0% - 2.2%
Oct 19 – Mar 20*	2232	46.9	*	1	0.04 %	0% - 4%	3	0.1	0% - 2.5%

Source:
NHS England (data only published annually in September each year)
RDaSH Ulysses Incident Reporting System

National Reporting and Learning System (NRLS April 2021 -March 2022 published October 2022. Further date not currently available NHS England » Organisation patient safety incident reports

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

The Rotherham Doncaster and South Humber NHS Foundation Trust continue to encourage reporting of incidents and reported incidents have increased enabling identification of themes and trends, and so maintain the quality of its services. By creating a culture of openness and a restorative just culture staff will feel able and confident to report incidents without fear of reprisal. Furthermore, with the introduction of Learning from Patient Safety Events (LFPSE) into incident reporting we foresee increased learning from patient safety events reported by our staff.

2.4 Performance against indicators set out in the Oversight Framework

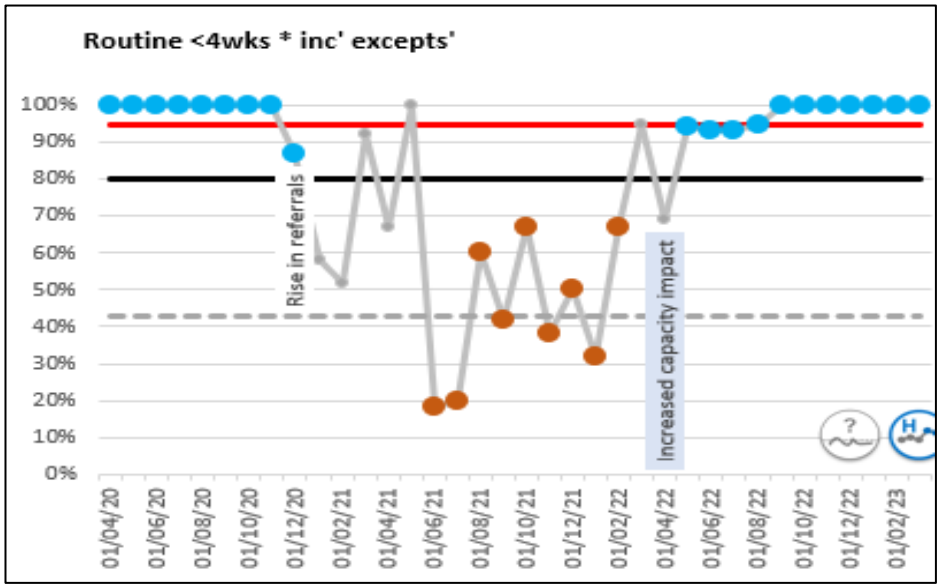
As predicted, there is a continuing increase of the population requesting Mental Health support which has resulted in increasing demand placed on our mental health and community-based services. Despite the increase in both demand and acuity of patients requiring treatment the Trust has performed well against the majority of its targets. The table below summaries the position against the Long-Term Plan targets.

Table 15:

Performance Metric - Provider Led Long Term Plan Metrics Only	22/23 RDASH Target	RDASH Actual 22/23	
		21/22	22/23
The number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended package care package in the reporting period within 2 weeks of referral	60%	93%	92%
Discharges Followed Up within 72 hours	56%	97%	90%
Perinatal Access	390	410	545
OAP bed days – inappropriate	676	3385	2253
IAPT Access	20800	16784	15468
CYP Eating Disorder Waiting Time – Urgent (within 1 week)	95%	79%	100%
CYP Eating Disorder Waiting Time – Routine (within 4 weeks)	95%	48%	95%

Within Children's and Young People Services

- There has been significant and sustained improvement in routine and urgent access to children and young people's eating disorder services with a year to date performance with 95% of children and young people accessing the service within 4 weeks of referral.



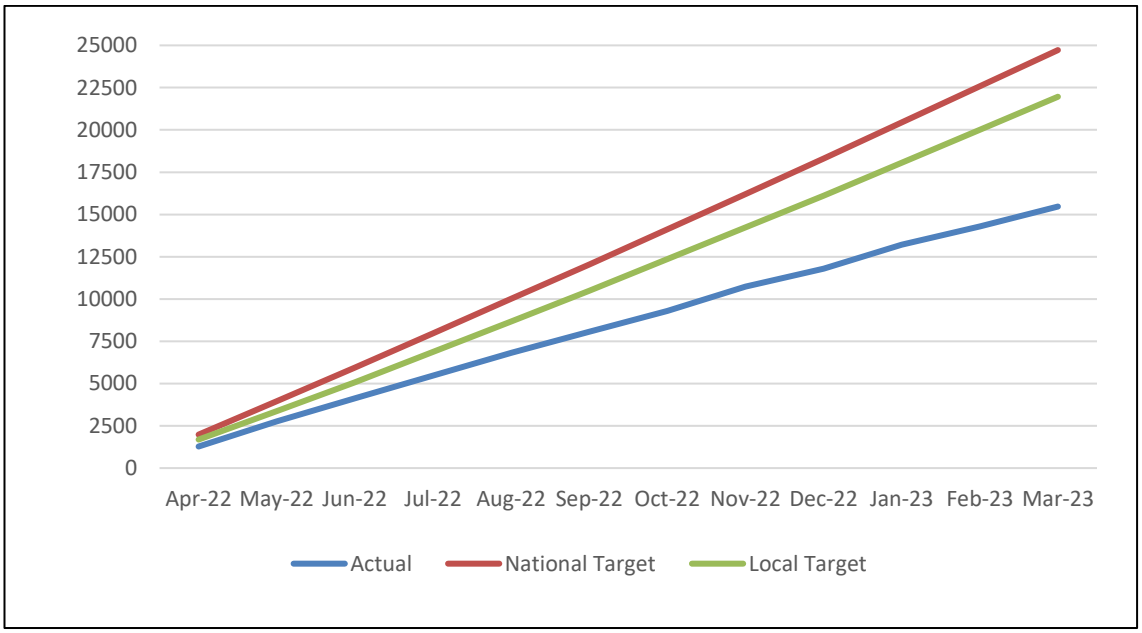
- We have also seen a very positive increase in the number of children and young people accessing our Children and Adolescent Mental Health Services.

Within our Psychological Therapies Services (IAPT)

- The service continues to achieve the 6 week and 18 week waiting times standards. In addition, recovery rates have seen an improved and sustained level of performance since April 2022. As the benchmarking below demonstrates waiting times and recovery rates remain above the target and continue to benchmark well nationally and against our nearest

neighbours.

- It has been recognised that along with the majority of other IAPT services we have not achieved the access target this year, however improvement work continues to maximize delivery against existing resources including using demographic data on health inequalities to inform targeted initiatives.



Within our Inpatient Services

- Within RDaSH, our ethos on patient flow is that people receive care in the most appropriate setting for them and if in a hospital setting then for no longer than clinically necessary. This recognises that inpatient admission can be distressing and disempowering for people and that timely discharge is as important as timely admission. However, there are many reasons why we may not be able to safely discharge patients as soon as they are clinically ready.
- The most obvious impact of discharge delays is that at high levels of occupancy, we often do not have an appropriate bed for someone needing admission (taking into account the type of bed needed and whether it is on a male or female ward) and are therefore forced to place people in beds outside their home area. Our first resort in this situation is to admit to RDaSH beds in other areas and our second is to agree 'mutual aid' with one of our ICB partners, most commonly Sheffield Health and Social Care Trust. However, if this isn't possible – with other trusts often experiencing the same bed pressures as RDaSH – we sometimes have to place people a considerable distance from home, which has included beds in London, Surrey and Somerset.
- After our use of out of area placements (OAPs) spiked in July and August 2021, we successfully reduced them down to a just a handful of days in July and August 2022, towards the national requirement to reduce them to zero. Unfortunately, bed pressures over winter have meant that these have gone up considerably again. Whilst this is clearly not good for patients, it is worth noting that our neighbouring providers have all faced similar challenges over the last six months, as shown in the NHS England Northeast and Yorkshire chart.
- Recognising that the challenges described are multi-factorial, we have put in place a comprehensive programme of work to improve patient flow on our inpatient wards and Whilst there is clearly still a lot of work to do, including further analysis of our data to better understand issues and challenges by locality, RDaSH is very firmly committed to working with system partners to deliver the national ambition of eliminating non-specialist acute out of area mental health placements by the end of 2023/24.
- It is noted that as a Trust we have committed to achieve the 2023/24 long term plan metrics in all but the metric relating to the inappropriate out of area placements where challenges

remain around high level of demand and patient acuity. We have put in place a comprehensive programme of work to improve patient flow on our inpatient wards and Whilst there is clearly still a lot of work to do, including further analysis of our data to better understand issues and challenges by locality, RDaSH is firmly committed to work towards reduction in inappropriate out of are inpatient days. Our commitments to the metrics are outlined in the table below.

Table 16:

Metric	2023/24 Plan
CMHT 2+ Contacts SMI 12 months rolling	8,533
CYP Access 12 months rolling	9,783
IAPT Access Total for year	21,960
Inappropriate Out of Area Placement bed days Total for year	1,220
Perinatal Total for Year	417
Virtual Ward Monthly Target by Q4	104

3. Other Information

This section provides an overview of the quality of care delivered by Rotherham Doncaster and South Humber NHS Foundation Trust. These indicators are in line with national strategies, priorities and requirements and with the quality priorities and strategic ambitions of the Trust. The following is a summary of the key indicators for each of the three quality domains of Patient Safety, Clinical Effectiveness, and Patient Experience.

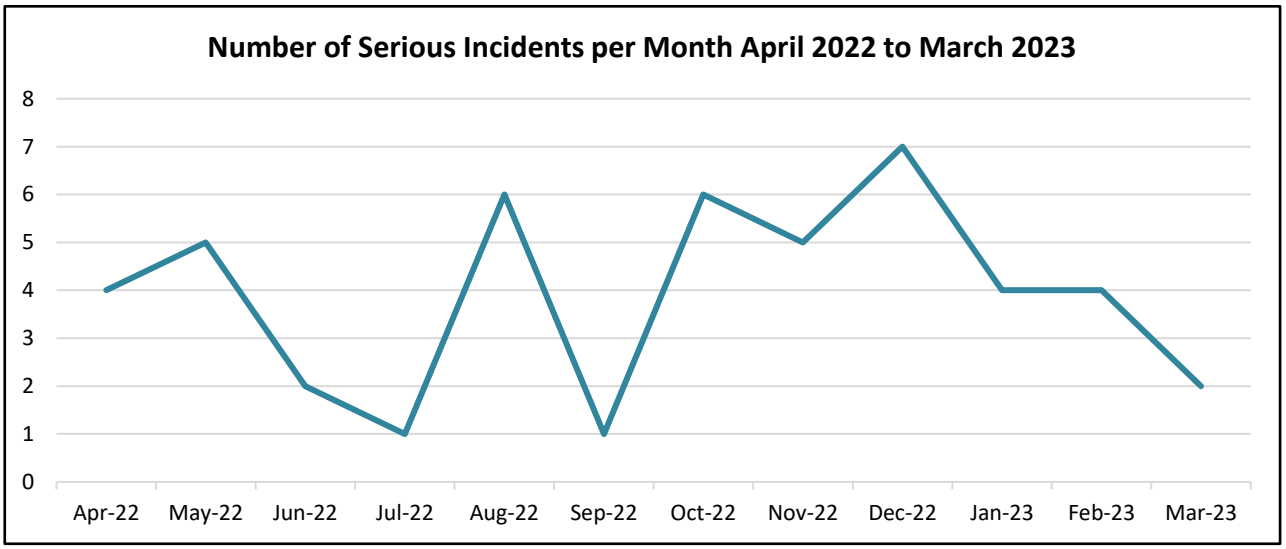
3.1 Patient Safety

3.1.1 Serious incidents: see also Section 2.3 Table 15 for reporting against core indicators regarding patient safety incidents

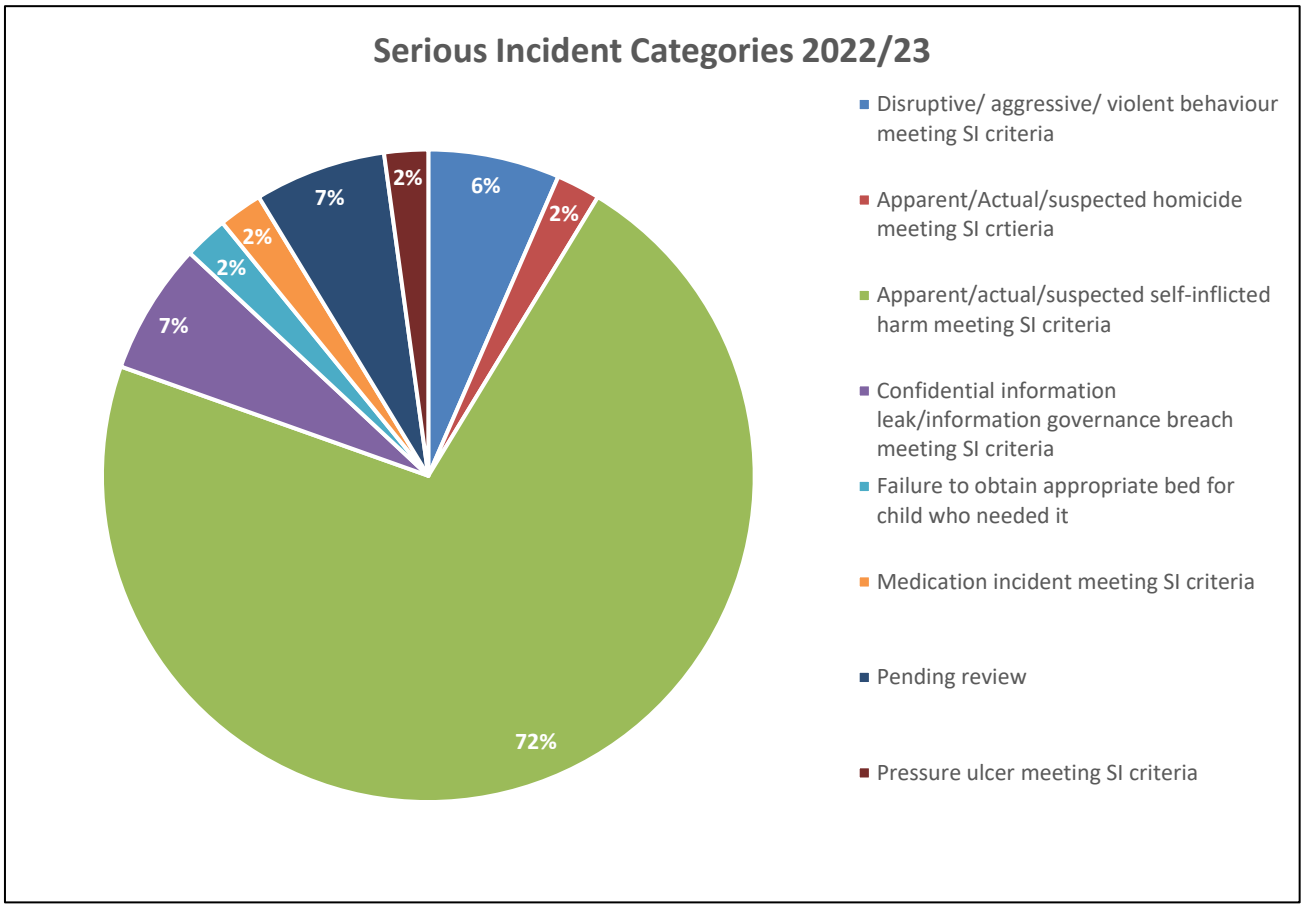
- **SIs reported**

Of the total number of incidents reported in 2022/23 46 serious incident investigations were commenced in 2022/23, an decrease of 8 (15%) from the previous year.

Table 17: Sis	2020/21	2021/22	2022/23
Total number of SIs reported for the financial year	41	54	46
Total number of SI investigations submitted to date	51	46	47



- **Categories of SIs**



The majority of Serious Incidents fall under the category of "apparent/actual/suspected self-inflicted harm meeting SI criteria". Actions taken to address this include:

- Deep dives are undertaken where clusters or themes arise
- An Environmental Risk in Clinical Areas exists to monitor environment safety
- The Trust is part of Place-based suicide prevention services and South Yorkshire and Bassetlaw and Humber Coast and Vale suicide prevention groups
- Mortality Structured Judgement Reviews are undertaken at the Mortality Operational Group
- Data is included in the monthly report to the Mortality Surveillance Group and in a quarterly report to the Quality Committee

- **Average number of working days to complete an SI investigation**

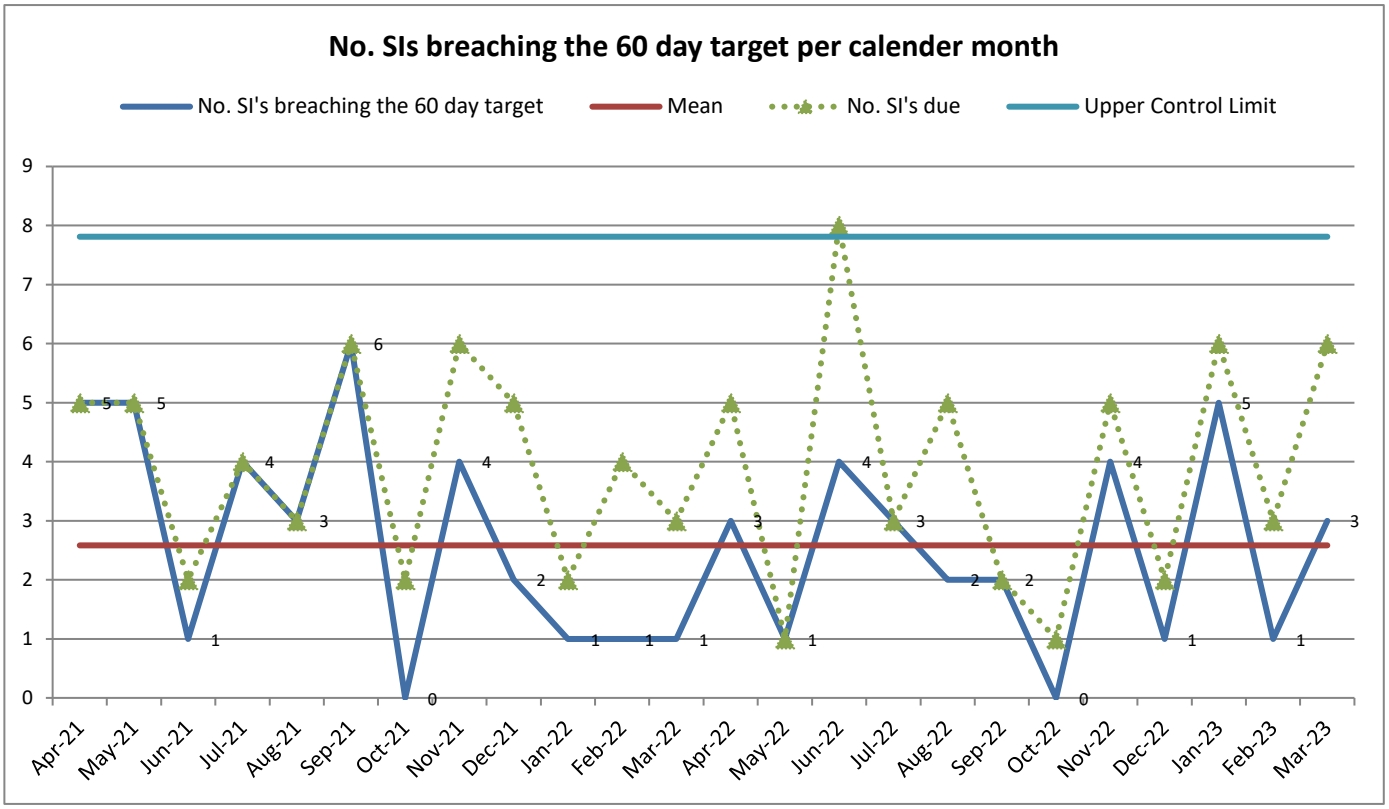
The current national SI Framework states that all SIs should be completed within 60 working days of the incident being reported to the commissioner.

The graph below shows the number of 60 working day target breaches per calendar month over a 2-year rolling period from April 2021 to March 2023.

In September 2021 it was agreed to review the SI breaches as follows, therefore the data will start to change from October 2021:

- **Not a breach-** where an investigation has taken over 60 days because of reasons outside of RDASH control- e.g., police investigations, 'stop the clock' situations, delays in information provided from outside RDASH, Safeguarding Adult Reviews.
- **Breach**- where an investigation has taken over 60 days because of reasons within RDASH control- e.g., delays in our processes, investigator capacity, delays in the 8-

week care group meeting, delays in sign off



A review has identified the following:

- Variation in Investigators submitting reports within the required timeframes
- Reports too lengthy and terms of reference not focused.
- Investigators capacity in being able to undertake both SI' and complaints investigations.
- Internal delays in the SI reviewing and sign off processes

We have undertaken some work to reduce the breaches in our reporting but maintaining the quality and thoroughness of our investigations.

- We have agreed with our ICB colleagues that SIs can be shorter and more focused on the period around the incident.
- We have amended the template to avoid repetition within the report.
- We have introduced virtual sign off for reports that have been completed but require urgent review prior to the Serious Incident meeting to avoid breaches.
- We have reviewed the process for requesting extensions and the approval process has been moved from the SIG group to the Deputy Director for Organisational Learning and Inquests

However, there is still further work to do:

- The Introduction of the National Patient Safety Incident Response Framework (PSIRF) will allow us to provide more focused and structured reports.
- All staff have completed or are in the process of undertaking the PSIRF Level 2 training.
- A review of our complaints process will include a review of team structures and to look at a more streamline and effective way of working for both complaints and SI's.
- We do not currently benchmark ourselves against other organisations however this is work that we will be undertaking in 2023/24. The Trust have led in setting up a partner

collaborative of local mental health Trusts to learn from each other.

- **Learning from SIs**

The learning from SIs is shared in a number of ways:

In 2022/23, we will be enhancing further the sharing of learning of SIs by:

- Development of a trust wide learning forum bringing together and triangulating learning from various sources
- To develop patient and carer stories
- Develop new ways of communicating learning using all types of media

- **Key achievements in 2022/23**

  - Maintained a high quality and performance in investigating serious incidents
  - Undertaken analysis of incidents in partnership with public health leads, identifying themes and trends as part of our ongoing suicide prevention work
  - Maintained tight deadlines to ensure that reports are provided to HM Coroner in the required timeframes
  - Development of a guide to relationship breakdown that has been cascaded to all place and Integrated Care board suicide prevention groups for wider use
  - Development of a co-produced guide for staff working with families and carers within mental health in patient services.

3.1.2 Safeguarding

The Trust continues to ensure that safeguarding is part of its core business and recognises that safeguarding children and adults at risk is a shared responsibility with the need for effective joint working between us and partner agencies. The Trust is committed to ensuring the principles and duties of safeguarding children, young people, and adults at risk are holistically, consistently, and conscientiously applied at the centre of what we do.

The Trust believes that everyone has a responsibility to promote the welfare of children,

young people, and adults, to keep them safe and to practice in a way that protects them. We give equal priority to keep all children, young people, and adults safe regardless of their age, disability, gender reassignment, race, religion or belief, sex or sexual orientation.

Our safeguarding team has substantial experience and expertise in safeguarding, with staff being from a diverse range of disciplines, including adult nursing, health visiting, midwifery, substance misuse, sexual health, school nursing and social work.

We have comprehensive safeguarding policies which contain information and guidance, including how to raise concerns if staff are worried about a child, young person, or adult at risk.

Recruitment practices and retention of a safe and expert workforce is vital. In addition, those who would harm a child, young person or adult at risk are discouraged from joining the organisation through safe recruitment processes. The Trust has a Person in Position of Trust policy in place to manage allegations made against a member of staff and safeguard individuals.

Governance and Accountability

The Safeguarding Assurance Group provides challenge and assurance around the safeguarding arrangements within the Trust. Quarterly assurance reports are shared with the Safety and Quality Operational Assurance Group and then presented to the Quality Committee.

Safeguarding Clinical Effectiveness Activity

The following table summarises the outcomes of safeguarding clinical effectiveness activity and assurance during 2022/23:

Table 18:

Activity	Scrutiny	Summary	Outcome	Key Findings
Referrals into children's social care	Safeguarding Assurance Group	Scrutiny of children's safeguarding referrals	Good	Practitioners did not always receive feedback following their referral
Non-recent disclosure of sexual abuse	Safeguarding Assurance Group	To provide assurance that staff are competent in managing disclosures of this nature	Good	Patients should be signposted to specialist support services
Person in Position of Trust (PiPoT)	Safeguarding Assurance Group	Compliance with policy	Good	IR1 incident report to be completed when a PiPoT is identified
Prevent	Safeguarding Assurance Group	To ensure staff have knowledge and understanding in relation to Prevent and know how to raise concerns	Good	Staff should understand what constitutes a PREVENT concern
Fabricated/Induced Illness	Safeguarding Assurance Group	Compliance with guidance	Outstanding	An SOP should be developed to provide clarity for staff who have concerns about PP/FII

Training

The delivery of safeguarding training remains a key priority for our safeguarding team, with the requirement that all staff are provided with the appropriate level of training commensurate to their role as defined in the Intercollegiate documents: Safeguarding Children and Young

People: Roles and Competences for Healthcare Staff (2018), Looked After Children: Roles and Competences for Healthcare Staff (2020) and Adult Safeguarding: Roles and Competencies for Healthcare staff (2019).

The aim of the safeguarding training is to ensure that every member of staff is aware of their safeguarding responsibilities, recognises abuse and knows what to do about it, as the minimum requirement. All training delivered by the team meets national standards as described in the Intercollegiate documents.

The Trust contributes to the delivery of multi-agency training programme developed by the Local Safeguarding Children's partnerships and Safeguarding Adults Boards. This includes the Graded Care Profile 2 training in Rotherham and Doncaster.

As a provider of NHS care we are required to have mechanisms in place to train staff to understand the risk of radicalisation. Mandatory Prevent training in line with NHSE Prevent Training and Competencies Framework is accessed by our staff via e-learning.

The Domestic Abuse Policy has been reviewed and updated to include supporting staff who are experiencing domestic abuse. In addition, a Domestic Abuse Level 2 training package has been developed and delivery of this package commenced in January 2023.

The table below shows Trust compliance with safeguarding training as of March 2023 and compares data to the previous year. There is an increase in compliance in every subject.

Table 19:

Subject	Target	March 2022	March 2023
Safeguarding Adults Level 1	90%	96.32%	98.67%
Safeguarding Adults Level 2	90%	92.84%	95.58%
Safeguarding Adults Level 3	90%	56.24%	77.37%
Safeguarding Children Level 1	90%	96.29%	98.75%
Safeguarding Children Level 2	90%	93.06%	96.99%
Safeguarding Children Level 3	90%	67.32%	79.55%
Prevent Level ½	95%	96.70%	98.47%
Prevent Level 3	95%	94.50%	94.79%
Domestic Abuse Basic Awareness	90%	81.82%	94.70%
Domestic Abuse Level 1	90%	93.16%	97.77%
Domestic Abuse Level 2	90%	78.73%	79.47%

Safeguarding supervision

Safeguarding Supervision Safeguarding supervision is fundamental in supporting practitioners in delivering high quality care, providing risk analysis and individual actions plans. Supervision ensures that practice is soundly based and consistent with Local Safeguarding Children Partnerships, Safeguarding Adult Boards, and organisational procedures.

Safeguarding supervision is mandatory for all staff working with children & families. The Trust uses a cascade model for facilitating safeguarding supervision and supervisors act as a visible champion of safeguarding within their own service areas to provide a link between their colleagues and the safeguarding team. Ad-hoc supervision is available for any staff member who has dealt with either an adult or a child safeguarding issue and requires advice and support or wishes to discuss and reflect on their practice.

Multi-agency working

The Trust is fully committed to multi-agency working and ensuring that effective safeguarding arrangements are in place across each of the three locality areas the Trust operates in. This is achieved by:

- Membership of Doncaster Safeguarding Children Partnership (DSCP), Doncaster Safeguarding Adult Board (DSAB) and sub-groups of both.
- Membership of Rotherham Safeguarding Children Partnership (RSCP) and Rotherham Safeguarding Adult Board (RSAB) and sub-groups of both.
- Membership of North Lincolnshire Safeguarding Children Partnership (MARS) and North Lincolnshire Safeguarding Adult Board (NLSAB) and subgroups of both.

The Trust remains committed to active involvement in local statutory multi-agency reviews including Domestic Homicide Reviews, Safeguarding Adult Reviews, Child Safeguarding Practice Reviews and Learning Lesson Reviews. Any learning is disseminated across the Trust.

The Trust publishes an Annual Safeguarding Report that outlines the collaboration with Local Safeguarding Children Partnerships and Safeguarding Adult Boards alongside the Trust's safeguarding priorities.

3.1.3 Infection Prevention and Control (IPC)

Our vision is that no person is harmed by a preventable infection. The Trust has continued to make substantial progress towards achieving the Trust's key priorities. We promoted best practice in infection prevention and control and maintained our long held low incidents of healthcare associated infections within the Trust.

The IPC Clinical Nurse Specialists work together to provide leadership, advice, and support to ensure compliance with the Health and Social Care Act (2008). The team facilitates learning across the Trust through training, education and learning lessons from incident reports.

National guidance and initiatives have been key drivers for elements of our annual work programme, and this evolving work stream will continue into 2023/24.

Infection prevention and control is the responsibility of everyone, and success is achieved when everyone works together.

Key achievements of 2022/23:

- Continued low rates of Healthcare Associated Infections (HCAIs)
- Ongoing COVID-19 management and support to staff and patients
- Completion of the in-patient audit programme with all 19 wards being audited using the Tendable platform with positive results
- Dedicated Link Champions supporting their peers and colleagues to deliver safe care
- Completion of a Sharps Safety Audit by an external company, to support safety, training and compliance with legislation
- A positive Health & Safety Executive (HSE) inspection with only one area of improvement identified
- Partnership working between the IPC Team and The People Focused Group (PFG Doncaster)
- The visible and proactive approach of the IPC Team
- Positive learning around two cases of Clostridioides difficile Infection

Healthcare Associated Infections

Table 20: Notifications of Mandatory Healthcare Associated Infections

Indicator	2020/21	2021/22	2022/23
Escherichia coli (E. coli) bacteraemia	0	0	0
Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia	0	0	0
Meticillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemia	1	0	0
Clostridium *difficile* infection (CDI)	3	2	5
Source: Local Reporting System, cases as defined by Health Protection Agency Guidelines			

The 5 cases of Clostridioides difficile Infection (CDI) were investigated by the IPCT, (see table below) and post infection reviews (PIRs) completed.

Table 21: Clostridioides difficile Infection

Care Group	Service	Infection	Outcome
Doncaster Physical Health	Magnolia Lodge	CDI	Unavoidable with no lapses in care identified.
Doncaster Physical Health	Central Community Nursing Team	CDI	Unavoidable with no lapses in care identified.
Doncaster Physical Health	Podiatry / North Community Nursing Team	CDI	Unavoidable with no lapses in care identified.
Doncaster Physical Health	Central Community Nursing Team	CDI	Unavoidable. Lesson learnt around delays in sending a stool sample. The patient was not harmed by the delay.
Doncaster Physical Health	South Community Nursing Team	CDI	Unavoidable. Lesson learnt around delays in sending a stool sample. The patient was not harmed by the delay.

The PIRs were undertaken within the Trust as services within the Trust were providing care at the time of the positive results, although none were attributable to Trust services.

There was a delay in sending a stool sample for two of the cases. A delay in specimen collection may contribute to delays in diagnosis and treatment, with a greater risk of severe infection and potentially life-threatening illness. The two patients were not harmed by the delays.

The learning from these PIRs has led to stool specimen containers being part of the core bag used by the community physical health nursing teams. This should reduce the delay in sending a stool sample. The learning from these two cases was disseminated to the Teams involved and will be highlighted in a learning brief in Q1 2023/24.

Outbreaks of Infection

- There have been 4 outbreaks of Norovirus/diarrhoea and vomiting
- There have been 0 outbreaks of Influenza Trust wide.
- There have been 41 outbreaks of COVID-19 across the Trust.

The management of outbreaks remained the most challenging work stream of the IPCT in 2022/23.

The IPCT provided support and guidance daily to affected inpatient areas utilising clinical area visits, telephone updates and emails.

Outbreak Control Group meetings were held and were chaired by the Director of Infection Prevention and Control or Deputy, with representatives from the care groups, outbreak area, Human Resources and IPCT. All outbreaks of COVID-19 were reported via the national reporting system and local Public Health England (PHE) and South Yorkshire Integrated Care Board (SY-ICB) were notified.

Recommendations were discussed at the outbreak meetings and actions agreed. Actions were addressed by the ward managers and reviewed by the IPCT on follow up support visits. All actions have been completed.

At the end of the outbreak summary reports were completed and distributed across the care groups to ensure learning took place.

Link Champions

The IPC Link Champions are encouraged to provide information at ward / clinic level using information boards. A wide range of information is displayed and disseminated to patients, visitors and colleagues. Link Champions are encouraged to change the board content on a quarterly basis and to consider any seasonal or current IPC issues such as influenza, norovirus, food poisoning etc.

The pandemic has been a very difficult and challenging time for everyone and the Link Champions have been invaluable, working diligently to maintain a safe environment within their work areas and supporting colleagues and patients with infection prevention and control measures.

Four Link Champions are currently undertaking the Florence Nightingale Foundation course 'Developing Health Care Support Workers to be Infection Prevention Control Champions'. The purpose of the course is to develop nursing, midwifery and allied health professional leadership identity, capacity and capability to influence organisational and patient outcomes at a local, systems, national and international level of healthcare delivery.

Mandatory Training

Standard Precautions Training:
Level 1 is for all non-clinical staff and is required every three years.
Level 2 is for all clinical staff and is required annually.

The training is completed by eLearning. A paper-based version of the training is available for staff groups unable to access e-Learning. This has been utilised primarily by staff from the Estates and Facilities department with limited access to IT. For these groups of staff the knowledge and learning post training is assessed by the individual's line manager.

Compliance is monitored monthly by the IPC team and data sent to Care Groups so gaps can be addressed. In 2021/22, Doncaster was one single care group and was split between mental and physical health in 2022/23.

Table 22: Level 1 Standard Precautions Training Compliance

Care Group	Compliance 2021/22	Compliance 2022/23
Children's	96%	98%
Doncaster Mental Health	96%	96%
Doncaster Physical Health		98%
Rotherham	95%	96%
North Lincs	97%	96%
Corporate	97%	96%
IAPT	99%	99%
Overall Trust Compliance	97%	97%

Table 23: Level 2 Standard Precautions Training Compliance

Care Group	Compliance 2021/22	Compliance 2022/23
Children's	88%	93%
Doncaster Mental Health	89%	89%
Doncaster Physical Health		91%
Rotherham	88%	91%
North Lincs	90%	91%
Corporate	87%	100%
IAPT	95%	100%
Overall Trust Compliance	***89%***	***91%***

Additional Training

The IPCT delivered hand hygiene training to members of The People Focused Group (PFG Doncaster). The session included theory around why hand hygiene is important, in relation to reducing the risk of cross infection, followed by practical hand washing using the "glow and tell" UV light box. Further partnership working is planned with the peers from the PFG.

Patients in Amber Lodge are also supporting the IPCT with a "bare below the elbow (BBE)" campaign. They are working on producing a short, animated video to highlight the importance of hand hygiene and the need for clinical healthcare colleagues to be BBE.

3.1.4 Pressure Ulcers

All Trust acquired Grade 3 and 4 pressure ulcers are reviewed by a multidisciplinary internal team of experts. The root cause and any lapses in care are established, themes and trends and learning are identified and are cascaded to the multi-professional Pressure Ulcer Harm Reduction Group. During 2022/23 the structure has been strengthened to ensure there is more robust feedback of cases, there is a patient Safety Partner voice included and that quarterly

feedback is shared.

A three-stage educational package has been developed to be cascaded out across the Trust to ensure the protection of our patients skin is a priority for all practitioners. In addition, a Wound Response Action Pack (WRAP) has also been developed as a first line preventative response for Allied Professionals and partners to protect skin integrity.

During 2023/24 partnership working with Yorkshire Ambulance Service (YAS) will be strengthened and a trial of the WRAP pack and training for YAS staff will be rolled out.

3.2 Clinical Effectiveness

3.2.1 Clinical Policies

Clear, comprehensive, and up to date policy documents, that can be easily located and understood by everyone are a crucial element of a safe, effective and caring organisation.

The Clinical Policies Review and Approval Group (CPRAG) provides assurance to the Board that:

- The Trust has a robust framework for the ratification of all clinical polices through a structured review and approval process.
- In accordance with relevant legislation and guidance, the Trust is fulfilling its statutory duty to have up to date, evidence based clinical policies in place.
- Appropriate consultation of clinical policies has taken place.
- All clinical policies are reviewed, ratified, and reported in accordance with the Trust's Procedural Documents (Development and Management) Policy.
- Scrutiny and challenge of all clinical policies content takes place to ensure they are fit for purpose in:
    - providing guidance and standards for staff in safe working practices
    - promoting standardisation in the provision of safe and effective care and the management of risk.

Excellent progress has been made in 2022/23 to reduce the number of expired policies requiring review, from 13 in April 2022 to 5 in April 2023. Note that when referencing expired policies this is in relation to the three-year review, not expiring the five-year mandatory review period. The Clinical Effectiveness Team continue to successfully provide an increased level of support to Policy Authors and Owners.

Progress has been achieved to:

- Develop a new policy template which has been rolled out for use with Clinical Policies which includes a quick guide to give the end user a clear summary of the contents of the policy and an interactive contents table which allows the end user to easily navigate to the relevant section of the policy.
- Redesign the webpage for all policies, reducing the number of clicks to access and improving navigation for end user.
- Standardise and rationalise the policies considering how they match up to work as imaging and work as performed to ensure that there is not a theory to practice gap in the application of policies.
- Map the policies to others and job roles and functions to improve applicability and application of policies.
- Identify learning and how this can be used to further develop a culture of safety, evidence through qualitative and quantitative measure.
- Consider how the approach regarding clinical policies can dovetail with Corporate polices.

As the Trust moves to adopt the National Patient Safety Incident Response Framework (PSIRF) this may influence the clinical policies and systems and processes that support these. There is collaborative engagement between the Clinical Effectiveness Team and the groups and individuals leading on this work.

3.2.2 NICE quality standards

In 2022/23 the NICE centralised process was embedded across the Trust. The NICE Guidance Centralised Process meeting provides the NICE Leads the opportunity to meet monthly to discuss the recently published NICE Guidance, discuss applicability to services and supports consistency across the Trust. The group identify any guidance that requires a corporate review.

The Clinical Effectiveness Team have worked closely with the data warehouse team to develop a local database to record the reviews of NICE Guidance and the outcomes of any baseline assessments. This system is managed by the Clinical Effectiveness Team and updated centrally.

All guidance is now reviewed, and a response recorded centrally within 28 days of publishing. In 2022/23 139 pieces of NICE Guidance were published. 15 pieces of guidance were assessed as being core to one or more services, 7 were assessed as being relevant to one or more services, 32 were assessed as being for information, 54 were assessed as being not applicable.

There were a total of 33 baseline assessments (National Guidance or Clinical Guidance) or service improvement tools (Quality Standards) completed with a further 23 in progress.

Of the bassline assessment and service improvement tools completed 76% were fully compliant, 6% were not applicable, 12% were partially compliant and 6% were not compliant.

Actions have been agreed where an outcome of partially compliant was achieved.

Table 24: Completed baseline assessments with an outcome of fully implemented

Title	Care Group	Ward/Servic
NG89 venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism	North Lincolnshire	Mulberry
	North Lincolnshire	Laurel
	Pharmacy	N/A
NG158 Venous thromboembolic diseases: diagnosis, management and thrombophilia testing	North Lincolnshire	Laurel
	Pharmacy	N/A
CG170 Autism spectrum disorder in under 19s: support and management	Children's	N/A
NG197 Shared Decision Making	Children's	N/A
QS13 End of life care for adults	North Lincolnshire	Mulberry
NG205 Looked-after children and young people	Children's	N/A
NG209 Tobacco: preventing uptake, promoting quitting and treating dependence	Children's	N/A
CG150 Headaches in over 12s: diagnosis and management	Children's	N/A
NG158 Venous thromboembolic diseases: diagnosis, management and thrombophilia testing	North Lincolnshire	Mulberry
NG204 Babies, children and young people's experience of healthcare	Children's	N/A
NG213 Disabled children and young people up to 25 with severe complex needs	Children's	N/A

Table 24: Completed baseline assessments with an outcome of fully implemented		
Title	**Care Group**	**Ward/Servic**
	Doncaster Mental Health	Learning Disabilities
	North Lincolnshire	Mulberry
	North Lincolnshire	Learning Disabilities
	Rotherham	Learning Disabilities
NG217 Epilepsies in children, young people and adults	Children's	N/A
NG218 Vaccine uptake in the general population	Children's	N/A
	Children's	Covid
NG221 Reducing sexually transmitted infections	Children's	N/A
NG223 Social Emotional and Mental Wellbeing in primary and secondary education	Children's	Special School Nursing Team

Table 25: Completed baseline assessments with an outcome of partially implemented			
Title	**Care Group**	**Ward/ Service**	**Summary**
QS13 End of life care for adults	North Lincolnshire	Laurel	North Lincolnshire have discussed the unmet statement at their clinical effectiveness forum. NICE Lead is currently liaising with other Care Groups to identify how they have met the statements.
NG215 Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults	Pharmacy	N/A	Agreed to record partially compliant outcome with currently no evidence to suggest not working to the guidance. However to fully evidence this significant dip sampling would need to be undertaken. Currently there is no capacity to undertake this.
QS86 Falls in older people	Corporate	Trustwide	Action plan in place with deadlines to address unmet statements. Once the actions are completed a Trustwide falls audit will be completed as agreed as part of the 2022/23audit programme.

Table 26: Completed baseline assessments with an outcome of not implemented			
Title	**Care Group**	**Ward/ Service**	**Summary**
NG028 Type 2 diabetes in adults: management	Doncaster Physical Health	Long term conditions	The guidance is core but there are currently only 2 diabetes nurses that manage this service. It is understood that we as Trust are not able to deliver what is set out in NICE guidance due the number of diabetic nurses we have, this has been escalated and communicated to commissioners but there are currently no plans to increase numbers, therefore an action plan to align our services to guidance is not achievable.
QS201 Venous thromboembolism in adults	Pharmacy	N/A	At the time of publishing a Quality Standard tool was not completed as the Trust policy around VTE was being reviewed to align our practice to the standards relevant to the Trust and it would not have been clear if we were compliant with any relevant statements. A further review of QS201 is now required as the VTE Policy has been updated inline with NICE.

The new Trust Clinical Strategy promotes the use of NICE Quality Standards (where applicable and available) to underpin evidence-based practice and used as a tool to measure and improve the quality of care provided. This will be a key area of focus for 2023/24.

3.2.3 QUIT Programme

In 2022/2023 the QUIT team have gone from strength to strength, with the Trust being asked to take part in shared learning with other organisations due to the success of the service and how well the smoke free policy has been embedded within the Trust.

Over the last 12 months, 52 patients have reached a 4 week quit and 22 patients reached a 12 week quit. This success continues in the staff offer with 16 staff reaching a 4 week quit and a further 22 staff reaching a 12 week quit. The commissioning teams have praised the Trust for the high number of patient and staff quits that have been achieved as these figures are higher than was expected when the programme was originally designed.

Along with this achievement, the service has seen huge improvements in data quality and are now submitting a full data set to the Integrated Care Board and NHS England. The volume and complexity of the data required has made this an enormous task but the data now reflects the excellent work done by the Trust to support our staff and patients who smoke.

3.2.4 Non-medical Prescribing

The Trust has 215 Non-Medical prescribers consisting of 95 Community Prescribers and 119 Independent Prescribers. The Non-Medical Prescribing (NMP) Group meets quarterly and is chaired by the Trusts NMP Lead. The group develops and implements the principles of NMP across RDaSH and provides governance and assurance as outlined within the NMP Policy to the Trust Board via Quality Committee and Medicines Management committee.

During 2022 The current NMP Policy was reported to be complex, confusing, and had led to delays in prescriber's being able to prescribe once qualified. It was also noted that there was no minimal requirement for supervision or accountability for timely completion of the Annual Declaration. During October to January a full review of the NMP Policy was undertaken by a large group of professional across the Trust and included the Trust NMP Lead, Nurse Consultants, Chief Pharmacist a Doctor and Non-Medical prescribers. The team worked together to ensure governance, accountability and assurance was improved for all non-medical prescribing across the Trust. The final sign off for the Policy was completed on April 4th 2023 and included the following improvements:

- Processes have been streamlined and the Policy has a quick guide to ensure the policy is easy to understand and navigate.
- Each Care Group has a Nurse Consultant NMP Lead who has oversight of all prescribers and ensures new prescribing requests are clinically appropriate to job role, robust supervision and support is in place and the Care Group Director is sighted and in agreement.
- A minimum requirement for supervision to be completed every 90 days by an appropriately experienced and practicing prescriber.
- Annual declarations are required to be completed timely and the Care Group NMP Leads have oversight of and support prescribers to completed within the required timeframe.

The transition over to an electronic centralised database of all Non-Medical prescribers commenced in 2022/23 and has included the recording of NMP supervision on the Supervision Portal and including compliance on the 456 Supervision Report. During 2023/24 the function of the App Portal will expand to include reporting of Annual Declaration and Supervision compliance to provide assurance to the Trust that Non-Medical Prescribing practice is robustly supervised and safe.

3.2.5 Professional Nurse Advocate

Professional Nurse Advocacy (PNA) is a professional clinical leadership role introduced post pandemic by the Chief Nurse and NHS England and Improvement to introduce a framework for providing restorative clinical supervision for nurses using the A-EQUIP (Advocating and Educating for Quality Improvement) model.

The PNA role guides staff through a continuous development process that builds personal and professional nursing leadership and increases contribution to quality improvement. The PNA provides restorative clinical supervision which delivers elements of psychological support and develop holistic resilience and emotional wellbeing for nurses. The aim of restorative supervision is to address the emotional needs of staff while providing “thinking space” which reduces stress and burnout and in turn improves staff retention.

During 2022/23 the Trust has set up a PNA Council which ensures effective governance and processes are in place, leads strategic decision-making and directs the future of PNA professional practice within the trust. The PNA programme is hosted by Nursing Safety and Quality Team and each Care Group has a PNA Ambassador and offers supervision and support to the Care Groups PNA’s. The Trust has developed a plan on a page strategy and has the long-term ambition is to host one PNA per team.

3.3 Patient Experience

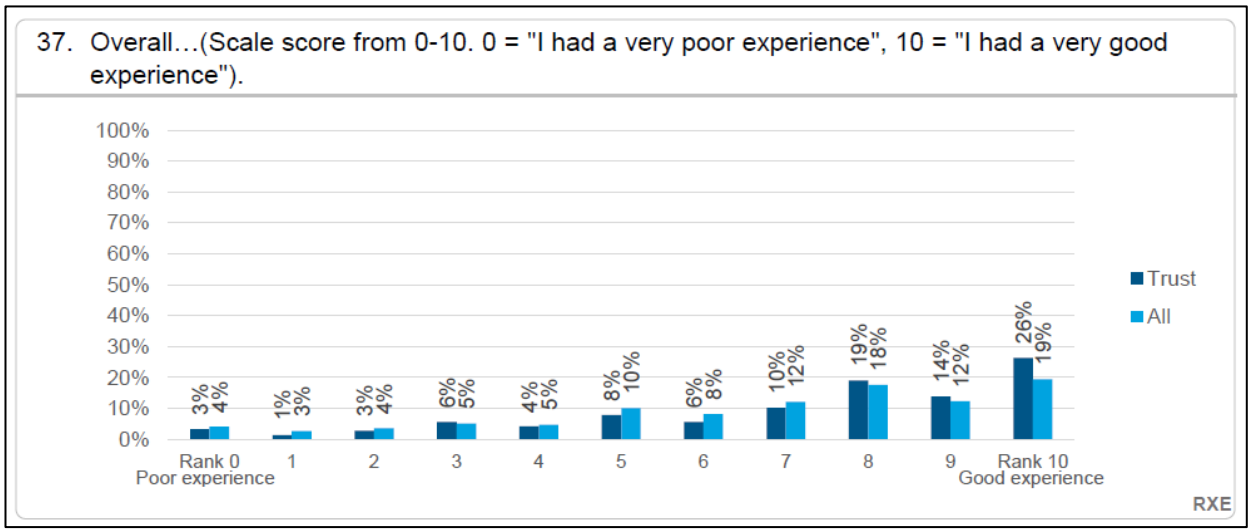
3.3.1 Community Mental Health Survey

The Mental Health Community Survey is an independently administered national survey of patients receiving mental health care in community settings. The survey is comprehensive and provides valuable quantitative data to facilitate comparison with other Trusts and benchmark our services numerically against a range of indicators. The results are provided to the Trust as a whole trust and it is not possible to break this down by geographical area.

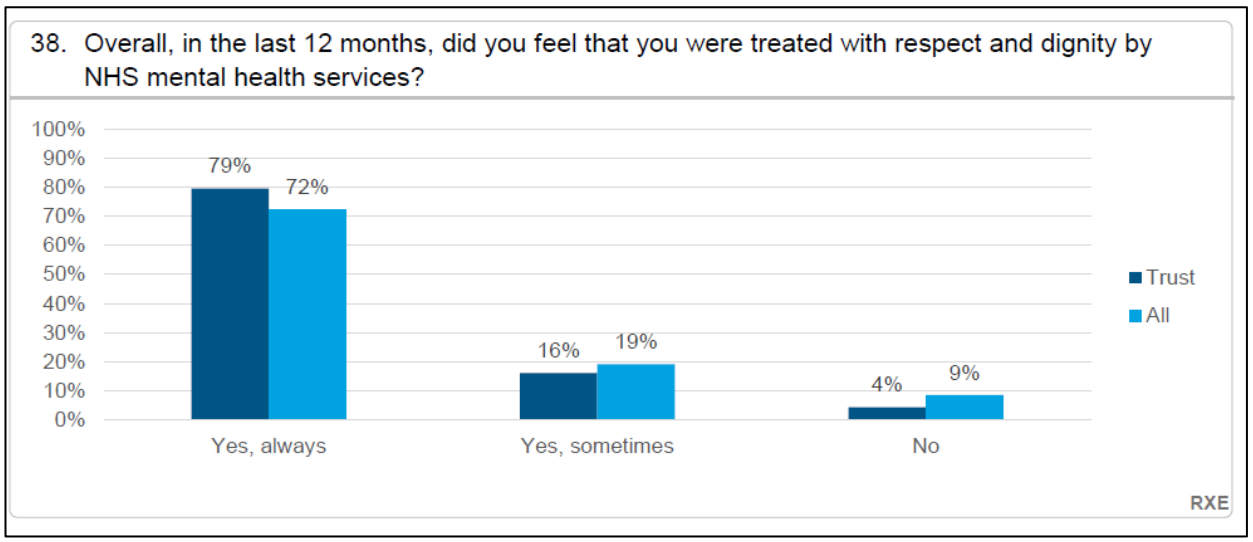
RDaSH took part in the survey in 2022, with 245 patients providing feedback. For each scored question in the survey, the individual (standardised) responses are converted into scores on a scale from 0% to 100%. A score of 100% represents the best possible response and a score of 0% the worst. The higher the score for each question, the better the Trust is performing.

Overall results for RDaSH were encouraging, with most scores for the Trust sit in the intermediate 60% of Trusts surveyed, with 9 scores in the top 20% range – an increase from 6 in 2021 – and 1 score in the lower 20% range.

The overall patient satisfaction outcomes saw 26% of patients score their experience with RDaSH as 10 (out of 10) – up from the 25% scored in 2021 - compared with a national average of 19%.



Patients also reported a positive experience of respect and dignity, with 79% reporting a good experience ‘always’ and only 4% responding ‘no’, again above the national average and an improvement on the 2021 score.



The 9 areas where RDaSH performed most strongly were as follows:

Table 27 : Areas where the Trust performed strongly							
					This Trust 2021		
	Lowest scoring Trust	Lowest 20% threshold	Highest 80% threshold	Highest scoring Trust	Number of respondents	Score	RAG
Q6. Have you received your care and treatment in the way you agreed?	74.4%	80.1%	85.0%	87.0%	158	86.9%	●
Q16. Were you involved as much as you wanted to be in deciding what care you will receive?	67.0%	71.8%	76.3%	83.4%	160	77.8%	●
Q19. Did you feel that decisions were made together by you and the person you saw during this discussion?	66.6%	75.8%	82.2%	87.4%	102	82.3%	●
Q25. Have the possible side effects of your medicines ever been discussed with you?	49.8%	55.2%	62.9%	70.5%	180	64.1%	●
Q29. Were these NHS talking therapies explained to you in a way you could understand?	68.1%	77.7%	84.6%	87.7%	65	85.3%	●
Q33. In the last 12 months, did NHS mental health services support you with your physical health needs?	32.3%	42.2%	51.1%	67.3%	117	53.2%	●
Q36. Have NHS mental health services involved a member of your family or someone else close to you as much as you would like?	55.2%	63.0%	69.4%	80.7%	160	73.0%	●
Q37. Overall…	61.3%	63.9%	69.5%	78.2%	216	71.9%	●
Q38. Overall, in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?	74.4%	78.9%	85.2%	90.8%	229	86.5%	●

These positive scores, within the top 20% of Trusts, surveyed are thematically linked, demonstrating a good level of partnership care planning and responsiveness. They suggest that patients overall felt:

- listened to, trusted and respected
- included in decision-making about their care
- well-informed in terms of medication
- supported to get the help they needed

The single question that fell below the lower 20% benchmark threshold was:

Table 28	Lowest scoring Trust	Lowest 20% threshold	Highest 80% threshold	Highest scoring Trust	Number of respondents	Score	RAG
Q13. Do you know how to contact this person if you have a concern about your care?	90.8%	94.9%	98.1%	100.0%	109	93.6%	●

While this result marks a decline from 2021, where none of our scores went below this threshold, it should be interpreted in the context of a score (93.6%) and a lower threshold (94.9%) that are both upwards of 90%.

The lowest overall scores for the Trust were as follows:

Table 29: Bottom 5 questions	Score
Q39. Aside from in this questionnaire, in the last 12 months, have you been asked by NHS mental health services to give your views on the quality of your care?	15.3%
Q34. In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits?	38.9%
Q35. In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work (paid or voluntary)?	39.2%
Q33. In the last 12 months, did NHS mental health services support you with your physical health needs?	53.2%
Q3. In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs?	60.5%

The single lowest-scoring question (39) clearly highlights the importance of the work outlined in this paper. On this question, RDaSH scored 3% below the national average. This suggests that only around **1 in 6** of our mental health patients are asked by us directly to provide their views on the quality of their care.

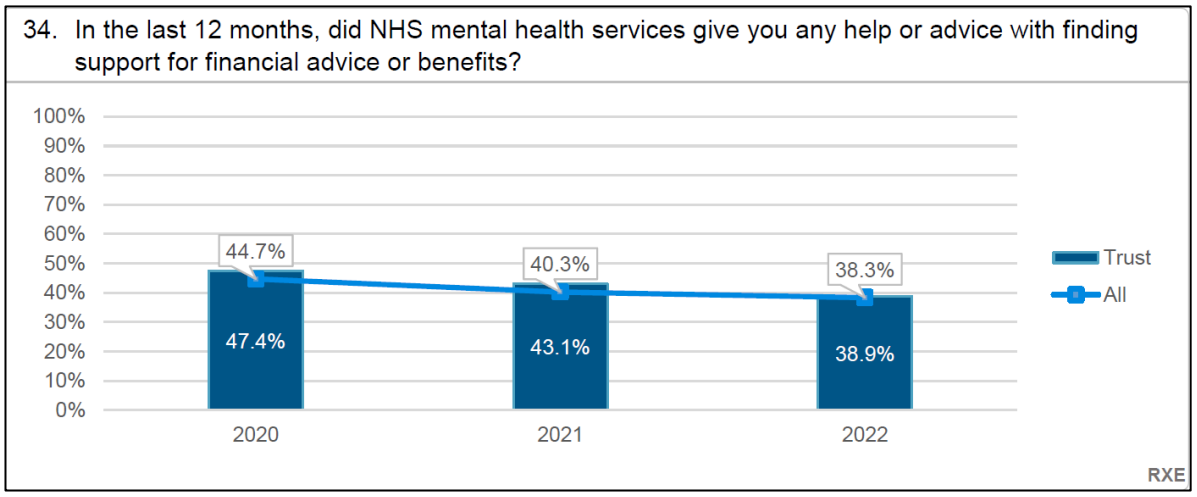
A specific action in response to question 39, has been to diversity the way in which service feedback, which includes the Friends and Family Test (FFT) is shared, with the intention of increasing the feedback response. A digital pilot was developed to test feedback through SMS messaging and launched on the 4 April 23 across trust wide IAPT services. This is currently being monitored and evaluated.

The progress against this is a core part of the plan, as well as some of the concrete next steps to ensure that all the different methods of engagement and feedback loops are being utilised effectively and consistently across the Trust. We have engaged directly with our people and communities around how patient experience and involvement should look in the Trust, and this has directly informed development of the first iteration of our plan – we are keen to ensure that this is not a single, fixed set of ideas, but an iterative process of continuous improvement, which will allow a flexible and sustainable approach in line with the changing needs of our local areas and populations. In this way, as we continue to consistently gather feedback using methodologies like the Survey, we can be responsive to any significant changes we record and track over time. The need to proactively increase the opportunities and processes by which we engage with patients has been acknowledged in the development of our Patient Experience and Involvement Plan, The LIVED Experience Plan, and is represented within one of the quality priorities for 2023/34.

Four of these questions (3,33,34,35) have in common a theme of **access to services and support.** This includes general access to mental health services, and being able to get help and advice on particular topics – specifically work, finances and physical health needs. With some of these areas, our performance as a Trust is reflected in the national picture, and scores across all Trusts have declined. The impact of COVID-19 in terms of service access is likely to have been a contributing factor nationally.

Although the question was in our bottom 5 results, RDaSH did outperform the national benchmark, suggesting that *relative to other Trusts* our ability to maintain service access has been positive.

RDaSH also performed less well in terms of providing help and advice around work (paid or voluntary) and financial advice of benefits. While the score was narrowly above the national average, there has been a significant decline since 2020, as illustrated in the example below.



The chart demonstrates that 8.5% fewer of our patients have reported receiving help of advice around financial advice or benefits – the gap is narrower regarding advice and support around work, at 2.1%. Both of these scores and trends are broadly reflected in the national picture, suggesting these elements of support are still in recovery from the impact of the COVID-19 pandemic.

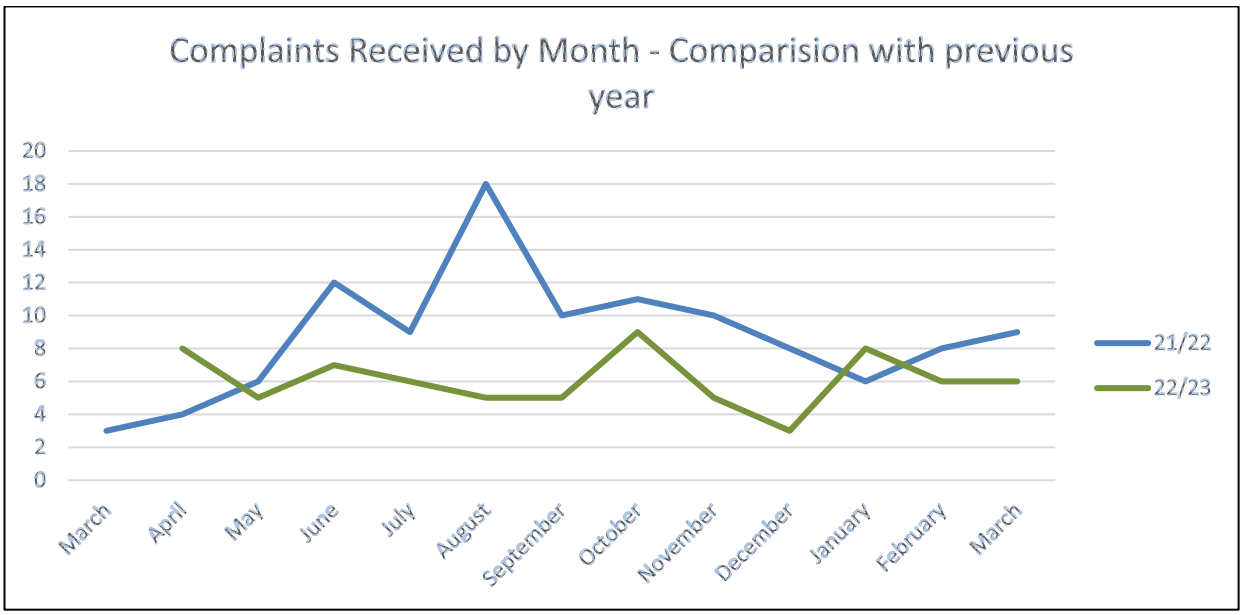
One of the actions taken has been to review the volunteering offer for the organisation, and to develop peer volunteer roles for people with lived experience of receiving health care. To date, we have developed peer support volunteer roles within mental health, and breastfeeding support, with the intention of expanding into learning disability and autism, and to focus on volunteer to career pathways both generally, and for people with a lived experience is using Trust services. This is a core action within the Volunteering plan within the LIVED Experience plan, which is one of the quality priorities for 2023/34.

We continue to take part in the national survey each year, and will therefore be able to track progress, and the impact of our new approach to Patient Experience, against both themes as a direct comparison.

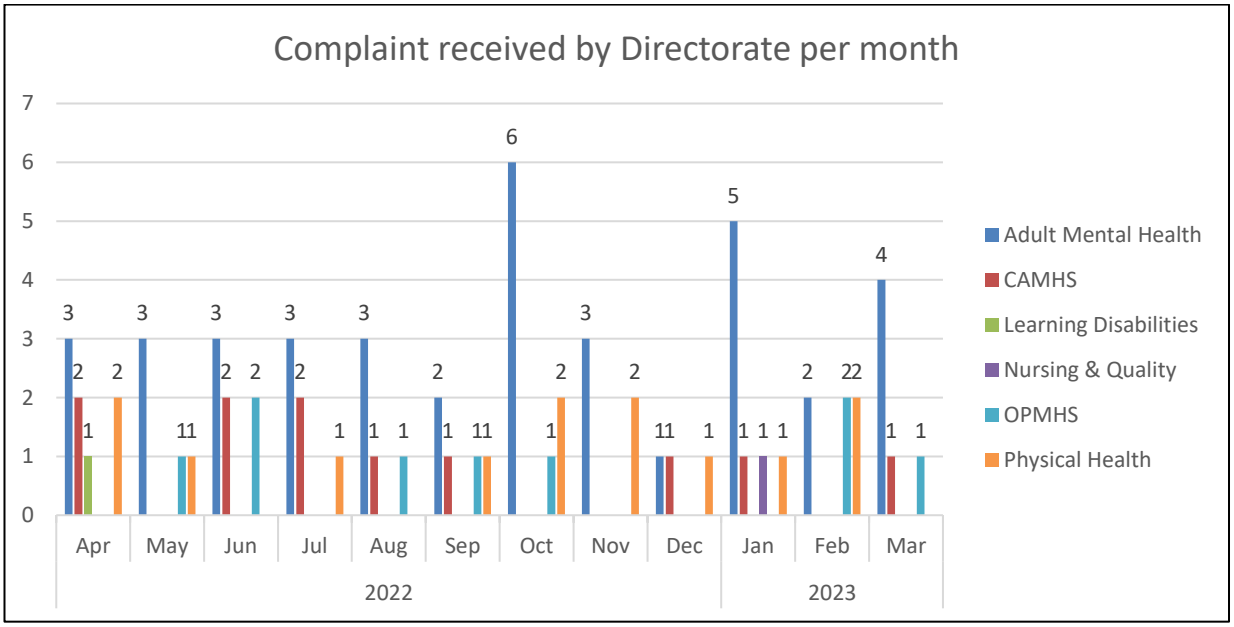
3.3.2 Complaints and Patient Advice Liaison Service (PALS)

Complaints

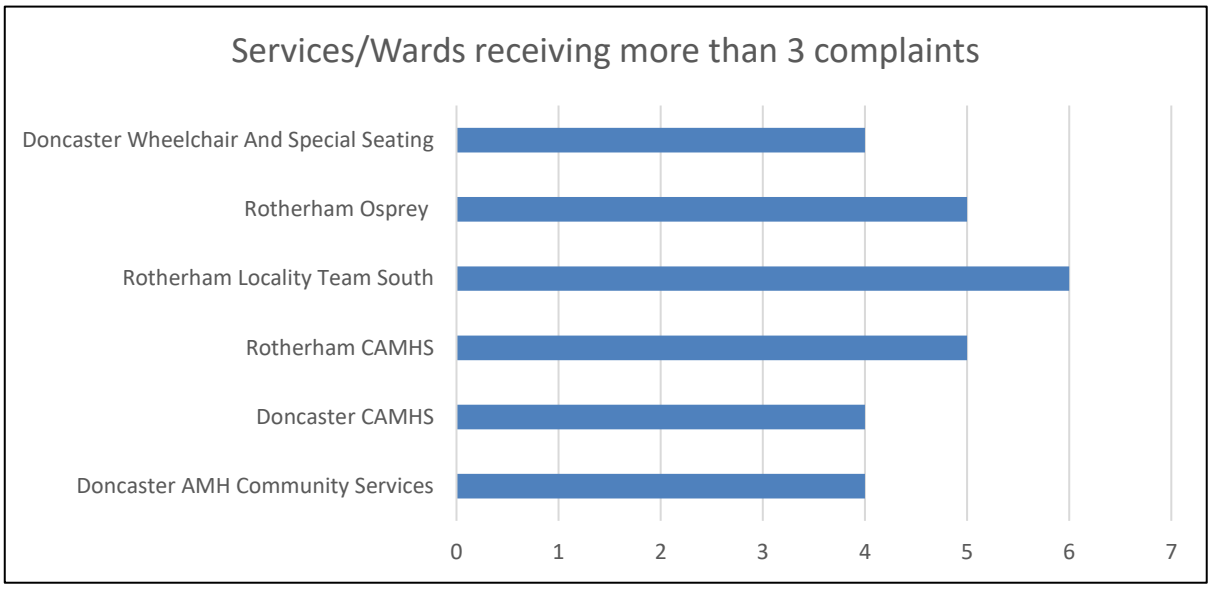
In the 2022/23 a total of 73 new complaints were received. This is a decrease of 19 (20.6%) in 2021/22. The chart below shows the number of complaints received by month Trust-wide in 2022/23 compared to 2021/22.



The graphs above and below shows a spike in October and January mainly due to Adult Mental Health Services. Adult Mental Health remains the area with the highest percentage of new complaints received during the year, reflecting the volume of activity in that area. Learning Disabilities only received 1 complaint during the entire year, the lowest number received by a service area. Aside from this peak, the number of complaints is in line with expected ranges.



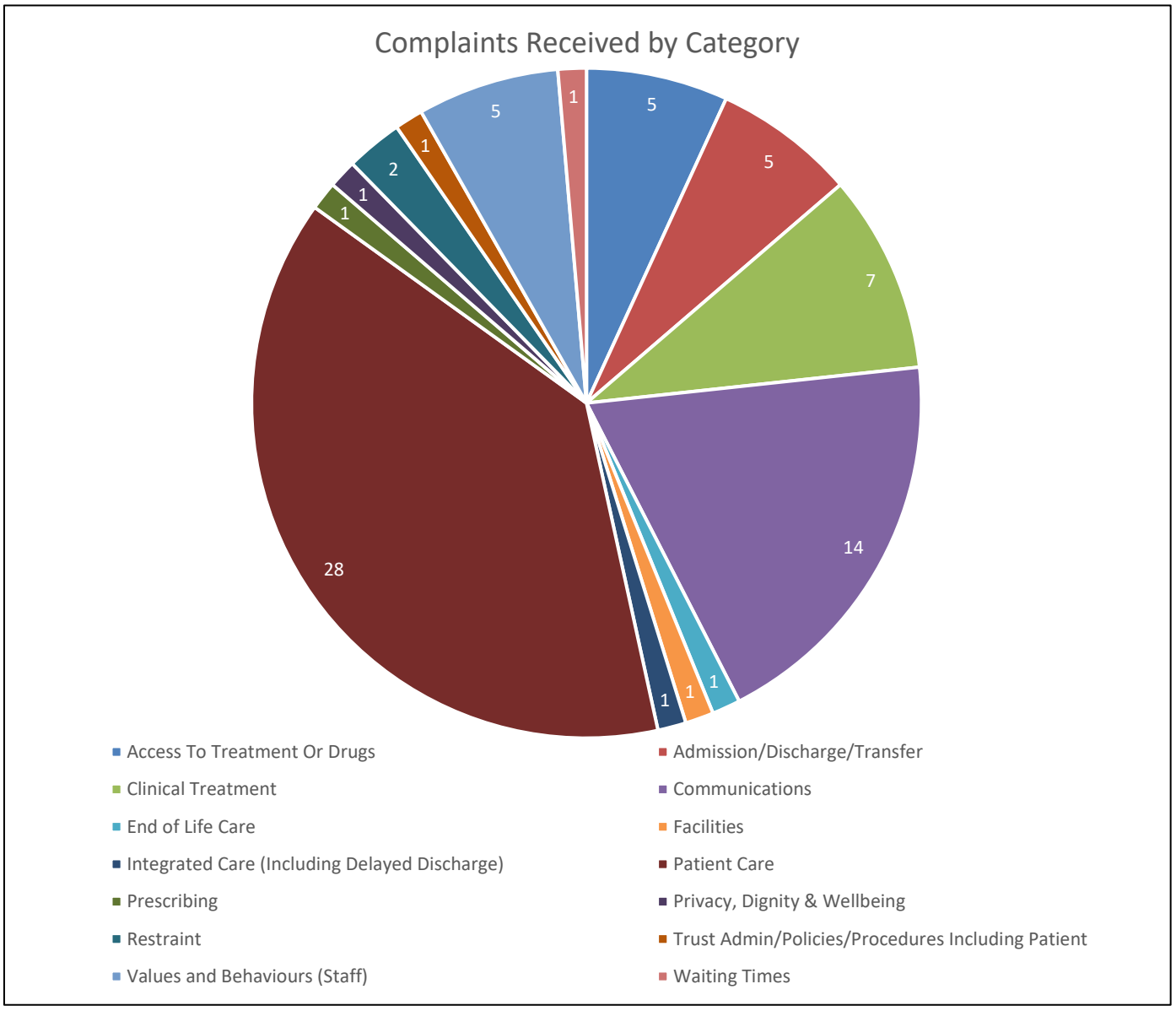
Most Trust services have received less than 3 complaints across the year. The services receiving more than three complaints in the period are illustrated below:



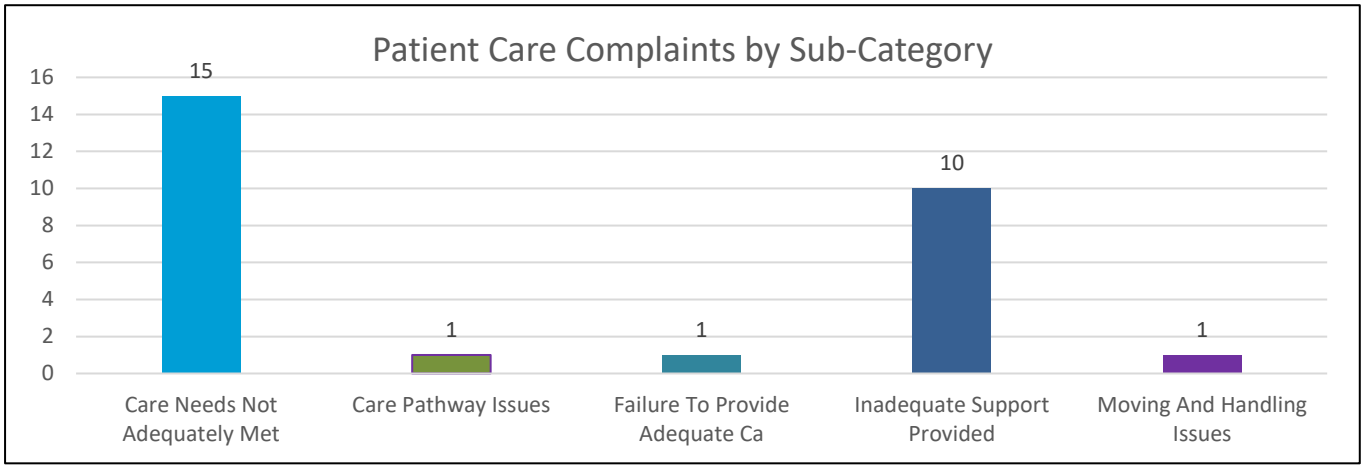
5 complaints were for Osprey ward an acute adult mental health ward. Inpatient wards however provide care for patients with higher acuity and additional challenges in terms of complexity. a member of the complaints team has been invited to attend the Rotherham Care Group Quality Assurance Meeting as a standing agenda item, to report on complaints received and help services to identify trends.

The area receiving the most complaints in the period is CAMHS, primarily Rotherham and Doncaster services. There is a national problem with the neurodevelopment pathway with long delays in awaiting assessments, but it is acknowledged that the CAMHS Service in Rotherham in particular is experiencing an unusually long length of time for neurodevelopmental assessments to be undertaken, higher than the national average. However, the number of formal complaints for Rotherham CAMHS has decreased over the year.

Across the Trust, thematically there is a wide variation of categories, with the highest proportion of complaints relating to patient care, see chart below.



In the Patient Care category, when those complaints are broken down further, the most prevalent category is 'Care Needs Not Adequately Met', followed by 'Inadequate Support Provided'' which together accounted for 25 individual complaints in the period. See chart below.



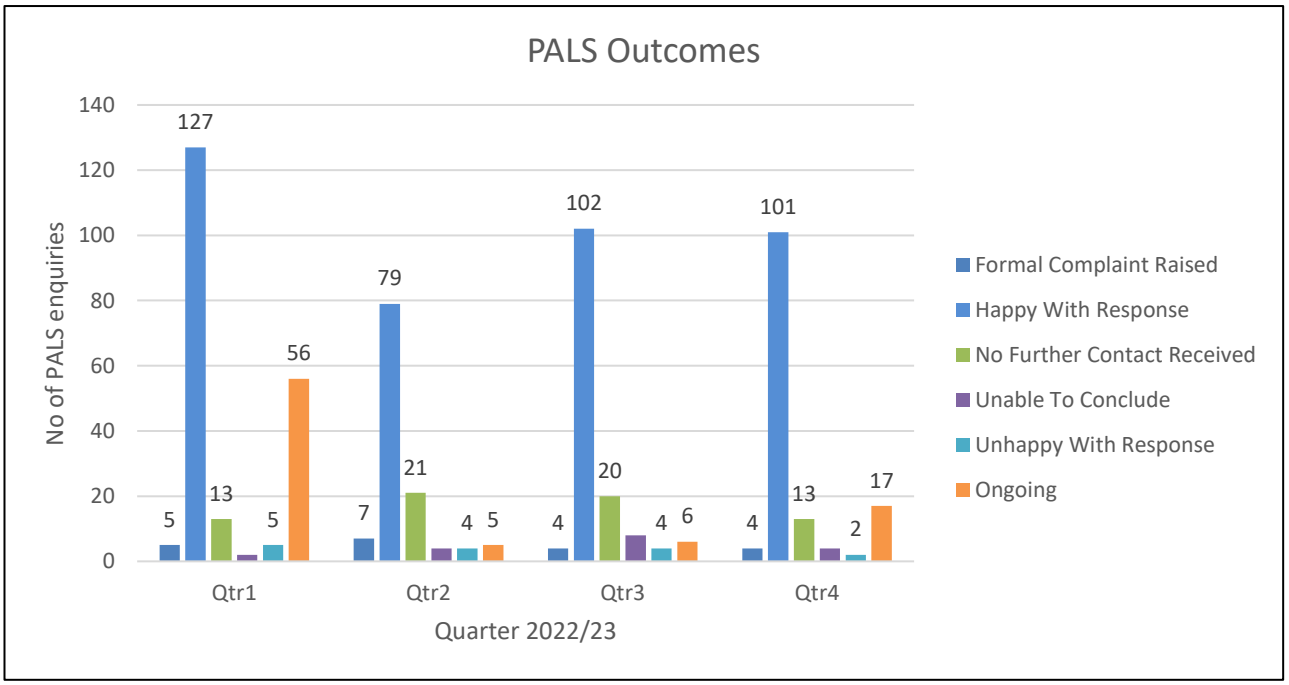
Comprehensive investigations have been completed in relation to the specific issues identified in these cases, and actions taken.

At present, data is not routinely collected on gender and ethnicity. Complainants are asked to complete a Diversity and Ethnicity form as part of the investigation process, but responses to this are variable. However, through early 2023/2024 work will be undertaken to ensure that this is collected more thoroughly for the patient (whether or not they are the complainant) and an analysis of the gender and ethnicity of patients/complainants as against our treated population and as against the resident population.

PALS

The number of new PALS concerns received by the Trust in total this year has followed a similar trajectory to complaints received, with an initial increase followed by a decrease to roughly previous levels. The overall number received has increased from last year's total of 512 by 101 enquiries to 613. However, more than 15% of these related to concerns about other organisations/providers which are signposted elsewhere.

The PALS team follow up on queries at the end of the process to check whether the concern has been resolved, any further signposting required and next steps. The outcomes from the PALS contacts at the end of the process is illustrated in the chart below. This demonstrates an effective investigation process, with the vast majority of concerns raised via this route resolved satisfactorily, and just 20 (3%) being escalated to formal complaints for the year. This is comparative with 2021/22 when 19 (4%) were escalated to formal complaint.



3.3.3 Your Opinion Counts

Your Opinion Counts continues to be the Trust's primary source of direct experience feedback from patients, families, and carers. It is also the primary means of collecting our responses to the Friends and Family Test question.

The number of forms received overall in 2022/23 has decreased by 198 (12%) from 1688 in 2021/22 to 1490 in 2022/23. It is useful to note that the number of forms received in 2019/20 was 826.

Table 30 YOCS Received	Care Group					
Quarter	**Children's**	**Corporate**	**Doncaster**	**North Lincs**	**Rotherham**	**Total**
Q1	65	201	149	63	37	515
Q2	29	2	184	74	35	324
Q3	50	1	135	57	39	282
Q4	49	0	197	83	40	369
Grand Total	**193**	**204**	**665**	**277**	**151**	**1490**

Compliments

The number of compliments received by the Trust has decreased overall from last year only by 5%. Doncaster Care Groups continue to receive the highest number of compliments with 331 compliments (5% increase), while North Lincs Care Group seen a drop in compliments by 48%. However, this system is reliant on staff recording compliments and it is recognised that they do not do this consistently and for all compliments received.

Table 31: Care Group	2022/23	2021/22
Children's	194	170
Corporate	12	24
Doncaster	331	314
North Lincs	76	145
Rotherham	15	10
Grand Total	**628**	**663**

Annex 1: Statements Clinical Commissioning Boards, Local Healthwatch Organisation and Overview and Scrutiny Committees, and RDASH Governors

Statements were received from:

- NHS South Yorkshire Integrated Care Board – Doncaster Place
- Humber and North Yorkshire Integrated Care Board
- NHS South Yorkshire Integrated Care Board – Rotherham Place
- Doncaster Health and Adult Social Care Scrutiny Panel
- North Lincs Council Scrutiny Panel
- Rotherham Health Select Commission
- HealthWatch Doncaster
- HealthWatch North Lincs
- RDASH Council of Governors

No statement was received from HealthWatch Rotherham.

NHS South Yorkshire Integrated Care Board – Doncaster Place

Doncaster PLACE Integrated Care Board (ICB) welcomes the opportunity to read and provide feedback to the Rotherham Doncaster and South Humber NHS Foundation Trust's (RDASH) document 'Annual Quality Report 2022/23'.

2022/23 has seen recovery from Covid and its impacts and it's been positive to see the continuous commitment that they have shown in delivering safe and effective care to patients throughout the year. The Trust received an overall rating of 'Requires Improvement', with ratings of 'Good' in the domains of Caring and Responsive and a rating of 'Requires Improvement' in the domain of Safe, Effective and Well Led. To support meeting their action plans and improving on their position they are undertaking trust wide re-inspections to ensure that there is ongoing embedding of learning and quality to establish the change that has taken place and strive for continuous improvement and care. These will be peer led quality reviews that will support understanding of how well they have implemented improvements and made a difference. They will also help to be prepared for any future CQC inspections by reviewing themselves against their standards, and key lines of Enquiry (KLOEs).

We note that there will be an accreditation process to demonstrate their current level of quality and aspirations to improve. In addition to this, the ICB looks forward to receiving the trusts revised long term strategy due to be published by September 2023, with safety and quality at its core.

The involvement of patients and carers and their experience has been a key piece of work over the past year with the recruitment of patient safety partners and the development of a patient safety training programme. Patient safety partners are actively involved in the work to implementation of Patient Safety and Incident Response Framework (PSIRF), especially in relation to patients and families/carers. They are also active in learning response forums which provides evidence that patient have a voice in the care they receive. This work is on-going to support the work of the PSIRF and the Learning from Patient Safety Events (LFPSE). The ICB will be keen to see how their programme of works around patient safety and safer staffing levels evolve over the next year and are keen to continue to work closely supporting patient safety.

During 22/23 the trust undertook a review of their complaints processes and moving forward they are realigning their complaints and investigation team to the care groups to promote and embed the new complaints standards. We will be pleased to see how this work is embedded in line with their complaints recovery plan to include support improved response times, training, and action plans. Their 5 key pledges should support commitment to continuously improve the experience of care for people: patients, carers, and families.

It is encouraging to see good engagement with the Medical Examiner (ME) team to support the roll out of the scrutiny of care patients receive and which also supports the processes embedded within the trust already to support all deaths of patients who have a learning disability.

Safeguarding continues to be central to all workstreams and RDASH are clear on the shared responsibilities and joint working with partner agencies. Commitment to ensuring the duties and principles of safeguarding children, young people and adults, keeping them safe features heavily in the work plans moving forward.

The ICB (Doncaster Place) CCG would like to take this opportunity to reiterate our commitment to working with and supporting the Trust's continued improvement journey.

Andrew Russell
Chief Nurse Doncaster ICB Place

12/6/23

Humber and North Yorkshire Integrated Care Board

Humber and North Yorkshire Integrated Care Board (HNYICB) welcomes the opportunity to provide comment on the RDaSH Quality Report for 2022/2023. Firstly, the HNYICB would like to take this opportunity to thank all staff across Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) for their hard work and dedication throughout the last year.

We recognise the challenges that remain in the recovery journey for service delivery in the aftermath of the Covid-19 pandemic across the health and care sector. Despite these challenges the ICB wish to congratulate RDaSH on continuing to drive quality improvement, ensuring it is at the heart of everything they do.

The Strategic Plan for 2021-2023 has been realised, and the ICB will look forward to receiving the revised iteration promised for September 2023. It is pleasing to note that the newly appointed Chief Executive, Toby Lewis, has outlined the intent to continue to support the ambition of 'Leading the Way with Care', learning from Covid-19 and ensuring connectivity with embedding the improvements made in delivering against the CQC action plan. The intention to continue to build on the three key areas of 'Insight, Involvement and Improvement', outlined within the strategic plan for 2021-2023, is duly noted as is the vision for building upon these with the nine relevant safety and quality priorities outlined for 2023/2024.

Of these nine priorities there is the ambition to improve the experience of care by harnessing the power of the lived experience, enhancing public and patient involvement as well as strengthening the volunteering offer. This aligns with the North Lincolnshire Place integration agenda recently launched in May 2023, 'Making it Real', and the ICB welcome working with RDaSH to achieve this.

Additionally, the ICB wishes to acknowledge some key achievements from the 2022/2023 quality report:

- The positive feedback within the domain of 'Patient experience of community mental health services' are above the national average by some margin, with the overall patient satisfaction outcome seeing 26% of patients score their experience with RDaSH as 10 (out of 10). In nine categories seeing the Trust as being in the top 20% of Trusts. This suggests that patients feel listened to, trusted and respected. This is to be applauded.
- The embedding of the NICE guidance centralised process has meant that all guidance is reviewed with a response recorded centrally within 28 days of the guidance being published.
- The commitment to a robust local and national audit programme – seeking to embed learning within a timely way.
- The significant and sustained improvement in routine and urgent access to children and young people's eating disorder services with a year-to-date performance with 95% of children and young people accessing the service within 4 weeks of referral.

Whilst the HNY ICB acknowledges the progress and improvement made by the Trust during 2022/2023 there remain some areas of challenge. As identified within the previous quality account report of 2021/2022, workforce issues remain a particular area of concern and as such remain relevant as an area of focus and support from the North Lincolnshire Health and Care Partnership Place (NLHCP). Work undertaken by the Trust to improve this position has been outlined within previous quality accounts and it is pleasing to note that the Trust have identified this within the nine safety and quality priorities, specifically priority number 8. This outlines the ambition to move from minimum safe staffing to optimal staffing on inpatient units and community services.

To conclude, the HNY ICB recognise the Trust's achievements outlined within this quality account and the ICB will continue to work closely with RDaSH as key system partners supporting the continued improvement journey.

Helen Davis

Helen Davis
Place Nurse Director
North Lincolnshire Health and Care Partnership

12/6/23

NHS South Yorkshire Integrated Care Board – Rotherham Place

NHS South Yorkshire Integrated Care Board (ICB) Rotherham Place, commend The Rotherham, Doncaster, and South Humber NHS Foundation Trust (RDaSH) and would like to thank their staff, for the continued dedication they have shown in delivering safe and effective care to patients throughout the year.

The ICB and RDaSH have worked together to make improvements in the three pillars of Patient Safety and Quality – Insight, Involvement, and Improvement - through engagement from clinicians and executives, at contractual meetings and other key committees between the two organisations.

The Annual Quality Account provides an opportunity to reflect both of progress and challenges.

The ICB are particularly keen to highlight a few of RDaSH's achievements: -

- Mobilisation of the addition resources made available by the ICB to ensure that Children and Young People access Community Eating Disorder Services within the national timeframe.
- Continued progress made to implement the recommendations from the CQC well-led inspection in November 2019.
- The development of a population health management approach within NHS Talking Therapies/IAPT to inform targeted initiatives.
- The Trust's drive to understand Learning from Deaths and the robust processes aligned to the Medical Examiners' role and Structured Judgment Reviews.
- Continued focus on best practice relating to infection prevention and control.
- The Trust has reported no Never Events.

As we develop and strengthen working across the ICB places, we look forward to identfiying and sharing best practice on Pateint Safety and Quality with our Doncaster colleagues.

Yours sincerely

S. K. Cassin

Sue Cassin
Chief Nurse
NHS SY ICB Rotherham Place

Jason Page
Medical Director
NHS SY ICB Rotherham Place

17/5/23

Doncaster Health and Adult Social Care Scrutiny Panel

The Chair on behalf of Doncaster's Health and Adult Social Care Overview and Scrutiny Panel is pleased to note that this is a Report showing a welcome return to a less restricted workforce following the pandemic. The reduction in complaints is very positive. The commitment of RDASH staff continues to be a key theme. It has been really encouraging to see the positive impact of FTSU and the continuing rise in champions as well as the Guardian role now in place. Safety Huddles are having results as well as input from neighbouring trusts. The continuing commitment to Virtual Wards working with the Acute Trust is being developed and expanded and should have a real impact as admission is not always beneficial and has already had supportive local press.

Schwarz Round feedback from staff is excellent and clearly appreciated. This should improve patient safety at the same time as having a positive effect on staff wellbeing.

It has been noted that there is a commitment to care for local people locally, and clearly this is always best. Would this include learning disability patients? The positive commitment to safe staffing and recruitment and retention is required to be a constant theme in the NHS going forward. I can see that RDASH are committed to alternative ways of Nurse and AHP Training.

Chair
Health and Adult Social Care Overview and Scrutiny Panel

13/6/23

North Lincolnshire Council Health Scrutiny Panel

North Lincolnshire Council's Health Scrutiny Panel welcomes the opportunity to comment on Rotherham, Doncaster and South Humber NHS Foundation Trust's (RDaSH) Quality Report 2022/23. RDaSH are a key partner and provider of local services, and members have built a valuable working relationship with Trust personnel over many years.

The Scrutiny Panel met with the Trust in June 2023 to discuss the Quality Account document, and performance generally. The Panel welcomes the progress made against the 2022/23 priorities, and fully supports the priorities chosen for 2023/24. We intend to invite Trust representatives to a future meeting to discuss these further.

The Panel is clearly aware of the Trust's 'requires improvement' rating, but we share the Chief Executive's view that this rating is not wholly reflected in the standards that are evident in many of the Trust's services. We also note the completion of all of the CQC's 'must do' and 'should do' actions. We therefore look forward with anticipation to a further assessment by the CQC.

Whilst the panel has sought further assurance on some indicators in the Quality Account document, where performance is not as good as would be expected, we note that performance against many other statutory or local targets remains very effective. We also note the very encouraging results of the NHS Staff Survey, where staff regularly report RDaSH as a good employer, who puts patients and others first.

Cllr D Robinson (Chairman),
On behalf of North Lincolnshire Council's Health Scrutiny Panel

16/6/23

Rotherham Health Select Commission

Members of the Commission appreciate having an opportunity to comment on the Quality Account draft for 2022-2023. It is positive to see within the draft strategic action plans for delivery of key priorities and improvement objectives. This greater clarity of purpose demonstrates improved leadership oversight over the last 12 months. As part of these specific action plans, Members would have liked to have seen stronger linkages between actions taken to progress those plans and measures of the impact of these actions on improved services and outcomes. In future conversations around quality, Members of the Commission are interested in seeing further breakdowns of how these actions are improving service quality and access for Rotherham residents, for example, in the development and implementation of the Home First model of care and transformation of community care.

We note the workforce challenges experienced by the Trust within recent years and affirm the resolve of the Trust to clear backlogs amidst these significant challenges. The urgency of this work is especially felt by Rotherham families awaiting assessment on the CAMHS Service neuro pathway. We note the implementation of internal audits in preparation for future inspection by the CQC which reflect good performance in many areas. We also note the rates of prompt follow up with patients after discharge that highly exceed the target. Measures like these demonstrate the care and commitment of staff who have supported local people under continued pressures throughout the year. We extend our heartfelt gratitude to the staff for their hard work and dedication.

Taiba K. Yasseen
Chair
Health Select Commission

15/6/23

Healthwatch Doncaster

Patient voice is imperative to help influence change and improve services. We're delighted that RDaSH have recognised the power of patient voice and what people can achieve when they are listened to and given the power to make positive change happen. When people have lived experiences and are willing to share their views and opinions on what works well and what can be improved. This really helps to build the next steps forward for RDaSH to deliver the services and quality they strive for on around the clock, twenty four seven basis - as we all know health and social care does not work to a nine to five schedule.

We appreciate the fact that RDaSH have recognised, that they still have work to do and there are improvements to be made. However some of the simplest of changes can make the world of difference to a person's experience, one of their priorities is to ensure every patient will be able to name and contact those caring for them. From the insights we have at Healthwatch Doncaster we can confirm, some people already know who their clinical professional is by name and feel they are able to contact them between appointments if there is a need to do so. We acknowledge this may not be the experience for everyone, but we look forward to hearing about people's experiences as services improve and the majority are able to tell us their experience is of a positive nature.

Service user feedback can be such a powerful tool and we were really pleased to hear people's experiences of services were 'better than expected'. To supersede someone's expectations is an exceptional achievement, you've delivered on their needs and then gone beyond, going that extra mile is something special. The feedback also suggested that people felt like they were listened to, trusted and respected, included in decision-making about their care, well informed in terms of medication and supported to get the help they needed. These foundations can last a lifetime - if maintained - thank you for creating these experiences it really does make a difference.

Over more recent months, there's certainly been a buzz around Doncaster with the implementation of new services and the recovery of Covid, it's clear to see that the Virtual Wards are a roaring success giving patients the treatment they need from the comfort of their homes plus with the addition of the Home First service, patients really will be receiving personalised care at it's best.

To conclude, there's strong evidence that RDaSH are working relentlessly to put the people that they care for at the very heart of their own care, allowing them to take the lead, enabling patient led care. And facilitating opportunities where people can build connections with their clinical teams for a true holistic approach. As an organisation who listens to people's feedback every day, we cannot wait to hear the great stories people are going to share with us around their experiences at RDaSH services.

Natalie Bowler-Smith
Engagement Development Officer
Healthwatch Doncaster

15/6/23

Healthwatch North Lincolnshire

Healthwatch North Lincolnshire welcomes the opportunity to make a statement on the Quality Account for Rotherham, Doncaster and South Humber NHS Foundation Trust.

Healthwatch North Lincolnshire recognises that the Quality Account report is a useful tool in ensuring that NHS healthcare providers are accountable to patients and the public for the quality of service they provide.

The report highlighted key achievements made against the 2022/23 priorities for improvement, especially noted are the changes made under the involvement pillar of safety and quality. This includes: the further development of a patient safety web page and the recruitment of two patient safety partners. It is also noted that, whilst some of the desired actions have been completed, more work continues in some areas such as the development of a patient safety partners forum.

Further development work has also been identified in the Safety and Quality priorities for 2023/24, which includes the improvement of experiences of care and opportunities for involvement.

In addition, we acknowledge the other achievements the trust has made particularly with regards to its mental health services including: the creation of a policy on the Mental Health Units Use of Force Act and the work completed so far around suicide prevention and learning from deaths. We also note the progress in the freedom to Speak up initiative (FTSU), such as the work being done to create a managers' handbook and the increased visible presence of the FTSU Guardian.

It was disappointing to note the down grading of the Combined Trusts mental health service to Requires Improvements and the Trusts overall rating of requires improvement. However, it is encouraging that all of the CQC's Must do and Should do actions have now been closed.

It is also disappointing that the Trust is not meeting the Learning Disability Improvements Standards for people with Autism, the Trust has stated within the quality account that this is because of variations in commissioning of services across the trust. However, the Trusts actions in response to the national concerns over patients with a learning disability and/or autism is positive and includes: sessions for middle managers on "could it happen here"? and a review of the seclusion policy.

The Quality Accounts contain information about the increasing demand for Mental Health Support and it was disappointing that the service did not achieve the access target for their Psychological Therapies Services (IAPT). However, the trust has exceeded the target for some of the indicators set out on the oversight framework, including Perinatal Access.

The results of the Mental Health Community Survey were largely positive especially service users' involvement in decision making connected to their care and in being treated with respect and dignity. Healthwatch North Lincolnshire accepts that, although the trust scored low on consulting service users over the last 12 months about their care the trust has provided a detailed account about how it will address this.

Finally, much of the information provided within the quality accounts, including reporting against core indicators, and sharing information from the Mental Health Community Survey, is stated for the Trust as a whole. It is felt that more detailed information by area would be useful so that members of the public and local organisations can gain a clearer understanding of the Trust's work at a local level.
Yours sincerely,

Jennifer Allen
Delivery Manager
Healthwatch North Lincolnshire

5/6/23

Rotherham Doncaster and South Humber NHS Foundation Trust - Council of Governors Statement for 2022/23

The Council of Governors is pleased to have the opportunity to comment on the Quality Report for 2022/23.

Governor engagement activities showed a steady increase during 2022/23 with the Covid-19 pandemic restrictions decreasing, allowing for more face to face activities to be attended and more opportunities for the Council of Governors to be closely involved with initiatives to promote and be aware of quality services within the Trust. Listed below are brief details of some of the ways that Governors have been included:

- The Council of Governors received update reports at its meetings that included specific updates on quality – in particular, focusing on the work of the Quality Committee. This section is presented to the Council of Governors by the Chair of the Quality Committee (Dawn Leese, Non-Executive Director). During the meeting Governors provide feedback and ask questions in respect of the information provided, seeking where necessary additional explanation and / or confirmation to hold the Non-Executive Directors to account and also demonstrating a keen interest in areas of work that will benefit the patients, service users, carers and staff of the Trust.
- A number of Governors have attended (virtually) and observed the bi-monthly Quality Committee and had first hand opportunity to see the Committee undertake its business and to hear and observe the challenge, support and discussion between members of the Committee and to see the progress made throughout the year.
- Governors have recommenced in the year their service visits. Governors, alongside of colleagues form the Board of Directors have attended services and had the opportunity to meet staff and to see and hear first-hand about working environment, the challenges they are faced and their success and moments of pride in delivering care to those in need.
- A number of Governors have attended (virtually and face to face) and observed the meetings of the Board of Directors held in public. This has also provided a valuable opportunity to see the wider business of the Board but also to see the input to the Board from the Quality Committee. Governors have engaged by asking questions relating to quality matters.
- Governors have attended a number of groups and events which are focussed on ways to involve and engage service users, carers and stakeholders in how the Trust delivers its services. These have included some large scale, public events such as Doncaster Pride and the Rotherham Show.

To enable Governors, individually and collectively to fulfil their roles and responsibilities, Governors have also participated in the following:

- Chair and Non-Executive Director appointment and (re)appointment processes – predominantly undertaken by the Governors on the Nominations Committee but with others involved too, resulting in recommendations being made to the full Council of Governors. Governors also participated in the recruitment to the position of Chief Executive in the year.
- The Governors have, during the year had access to events hosted by NHS Providers and a number of national and regional updates and conferences that have all contributed to a better understanding of the role and responsibilities. These have included Integrated Care Board meeting attendance and updates.

The Council of Governors support the content of the report as an open and honest reflection of the Trust's position, in line with that presented to the Quality Committee and Board of Directors.

The Council of Governors are committed to working closely with the Board of Directors, staff, service users, carers and public over the coming year to support the delivery of the quality priorities contained within the Quality Forward Strategy and understanding the progress on work

to improve the CQC rating. Governors would encourage the Trust to share positive feedback in addition to learning from areas of concern. The Council of Governors has identified three focus areas including Volunteering, Patient and Public engagement and Health promotion which it would like to work closely on with the Trust in 2023/24.

The Council of Governors welcomes and looks forward to continuing and enhancing its work, with support from the Trust, to more effectively hold the Non-Executive Directors to account for the performance of the Board of Directors. This includes active discussions between Governors who work with, and through, Non-Executive Directors and learn from the good practice of other NHS Trusts.

Council of Governors
19 June 2022

Annex 2: Statement of directors' responsibilities for the quality report

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.

NHS Improvement 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 NHS 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 2022/23 and supporting guidance
- 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 2022 to March 2023
    - papers relating to quality reported to the board over the period April 2022 to March 2023
    - feedback from commissioners:
    - NHS South Yorkshire Integrated Care Board – Rotherham Place 12 June 2023
    - Humber and North Yorkshire Integrated Care Board 12 June 2023
    - NHS South Yorkshire Integrated Care Board – Rotherham Place 17 May 2023
    - feedback from Council of Governors 19 June 2023
    - feedback from Doncaster Healthwatch organisation 15 June 2023
    - feedback from North Lincolnshire Healthwatch organisation 5 June 2023
    - feedback from Overview and Scrutiny Committee:
        - Doncaster Health and Adult Social Care Scrutiny Panel 13 June 2023
        - North Lincolnshire Health Scrutiny Panel 16 June 2023
        - Rotherham Local Authority Health Select Commission 15 June 2023
    - the trust's complaints report 2022/23 published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 and the quarterly reports for 2022/23
    - the latest national community mental health patient survey 2022
    - the latest national staff survey 2022
    - The CQC Inspection report dated 21 February 2020
    - the Head of Internal Audit's annual opinion of the trust's control environment (Interim Opinion 11 May 2023 / Final Opinion to be received by Audit Committee 27 July 2023)
- 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 NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts

regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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.

Toby Lewis, Chief Executive
30 June 2023

Kathryn Lavery, Chairman
30 June 2023

Annex 3: Glossary of Terms and Definitions

This section aims to explain some of the terms used in the Quality Report. It is not an exhaustive list but hopefully will help to clarify the meaning of the NHS jargon used in these pages.

360 Assurance	The Trust's Internal Audit service
CAMHS:	Child and Adolescent Mental Health Service
Care Programme Approach (CPA):	
	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.
CAS:	Clinical Alerts System
CQC:	Care Quality Commission
CQUIN:	Commissioning for Quality and Innovation
Dashboard:	Summary overview of key areas of performance
ESR:	Employment Staff Record – the national NHS staff record system
FTSU:	Freedom to Speak Up
IAPT:	Improving Access to Psychological Therapies
ICB:	Integrated Care Board
LeDeR:	Learning Disabilities mortality review
NHS:	National Health Service
NHS England:	Formally established as the NHS Commissioning Board on 1 October 2012, NHS England is an independent body at arm's length to the Government.
NICE:	National Institute for Health and Clinical Excellence
PSIRF:	Patient Safety Incident Response Framework
PSS:	Patient Safety Specialist
POMH-UK:	Prescribing Observatory for Mental Health UK
Quarter 1:	1 April – 30 June
Quarter 2:	1 July – 30 September
Quarter 3:	1 October – 31 December
Quarter 4:	1 January – 31 March
RDaSH:	Rotherham Doncaster and South Humber NHS Foundation Trust
SystmOne:	A clinical system which fully supports a ground-breaking vision for a 'one patient, one record' model of healthcare.
Tendable:	An online quality improvement assurance tool which supports services to undertake quality inspections/audits and receive immediate results.
Uysses:	The Trust's incident management system