Rotherham Doncaster and South Humber NHS Foundation Trust

Annual Quality Report 2021/22

V9

RDaSH leading the way with care

Quality Report 2021/22

1. Statement on Quality from the Chief Executive

I am pleased to introduce the 2021/22 Quality Report and Account for Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH).

This has been another year of ongoing challenges because of the COVID-19 pandemic, and I have been astounded by the degree of perseverance, tenacity and willingness to be supportive of each other that our colleagues have shown and continue to show. Despite any difficulties faced by them, they have continued to provide care with compassion, an aspect which has been recognised by CQC during Mental Health Act inspections they have conducted. As a Trust, our Board have openly recognised and acknowledged the value of colleagues throughout the year, and we have been pleased to reward them for their ongoing commitment.

The report will describe our progress against the safety and quality priorities in 2021/22 and set out our safety and quality priorities for 2022/23 as we continue to deliver the ambitions embedded within 'Trust Ambitions and Strategy Refresh 2021-2023'.

Despite the work of colleagues in all services across the Trust, it is inevitable that we will not always get it right. We continue to learn from where care has not been to the standard we would expect and endeavour to improve. This report will describe where learning has taken place and what actions have been taken to improve.

Following the publication of our CQC inspection report in February 2020 and the rating of *Requires Improvement*, an action plan was put in place to address the issues raised by CQC. The COVID-19 pandemic continued to impact on the Trust's ability to deliver on these actions at pace as patient care was prioritised under these exceptional circumstances. Nevertheless, work has continued to progress on delivery of the action plan throughout 2021/22 and most actions are now complete.

The NHS staff survey is carried out on an annual basis between September and November, with results published publicly in March 2022. This year the survey is aligned to the 7 key People Plan Promises, and I am delighted that in every one of these areas we performed better than the average. We will be working with colleagues to address concerns, make improvements and set some real ambition for improving both our response rate (for next year) and working conditions and experiences. I strongly believe the Trust is a great place to work and I am very pleased colleagues have given us these encouraging results

Of note, the Trust's results in the following categories were just 0.1 away from being the top scoring Trust:

- People Promise 1: We are compassionate and inclusive – Diversity and Inclusion
- People Promise 6: We work flexibly – support for work life balance
- People Promise 7: We are a team – line management
- Staff Engagement – Motivation.

In 2021/22, we were delighted to have won or been shortlisted for several awards:

- Leana Gater, E-Health/Social Media Support Officer scooped the North East and Yorkshire Region Health Care Support Worker Technology Award, judged by NHS England and NHS Improvement,
- Our Information Technology (IT) colleagues celebrated achieving a global best practice standard awarded by the Service Desk Institute
- The Communications Team clinched two highly commended awards at the national NHS Communicate Awards. The team won the accolades for their work on the Rethink Your Drink Doncaster campaign. The team won highly commended in the Working In Partnership Award and the Best Behaviour Change / Public Health Campaign Award.

- The Human Resources Team were finalists for the People Team of the Year – Public Sector at the 2021Chartered Institute of Personnel Development Management Awards. The nomination was for the support they have provided to the Trust during COVID-19

We were also delighted to be recognised nationally in 2021 as a Trust. The BBC interviewed Dr Navjot Ahluwalia, our then Executive Medical Director, on behalf of the Grounded Research Team for their work on the ComFluCov study looking into whether COVID-19 and flu vaccines can be administered at the same time. In addition, the Crystal Building housing our Doncaster CAMHS Service was awarded the honour of being the location for the winning garden design in the BBC;'s Big Bee Challenge and we hosted the Radio 2 Breakfast Show to reveal the winning garden.

As Chief Executive of the Trust, I am proud of this year's quality improvement achievements and confirm that to the best of my knowledge the information provided within this 2021/22 Quality Report is accurate.

Our annual report 2021/22 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

Kathryn Singh
Chief Executive
30 June 2022

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 RDaSH reflects the three pillars of safety and quality:

- Insight
- Involvement
- Improvement

Our refreshed safety and quality approach reinforces the importance of building a safety culture and addressing the needs of vulnerable groups. Underpinning a safety culture is a commitment to embedding Just Culture across the organisation and a systems approach to care delivery and learning.

The Trust has refreshed its Strategic Plan for 2021-23. This reflects some of the challenges that COVID 19 has highlighted, particularly in respect to weight of activity for the Trust and the disproportionate impact COVID 19 has had on members of our society.

Despite the challenges of COVID 19 we have made considerable progress against the priorities set within the Safety and Quality Delivery Strategy

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 Safety & Quality Plan has been developed to help implement a number of key actions to deliver the Trust's refreshed Strategic Ambitions. The achievements made from this plan are shown in Table 1 below.

Table 1: **Ambition 1: Trust Refreshed Strategy**	
Provide safe and effective care, first time, every time	
Action	**Achievements**
Improve the availability of 'live' patient safety data for clinicians and for assurance by implementing a programme of 'digital wards' across the Trust	✓ Oxevision is installed and in use on 11/12 inpatient wards, the remaining ward is being refurbished and the system will be installed as part of the refurbishment. There is excellent use across inpatient areas and the insight report identified that staff and patients who have been consulted about the impact of the system identified how they felt it improved safety of people. Over 22/23 the Trust will be exploring further functionality of the system to continue to improve patient safety and experience ✓ Perfect ward is now known as Tendable due to a change in the company name. All 19 inpatient wards are registered to use the system, 4 wards are regularly using the audits available and there is some usage by other areas. A community of Practice has been established to support routine uptake by other areas. This will be a continued area of focus as part of the Trust's Clinical Effectiveness arrangements with regular reporting through to the Safety and Quality Operational Groups
Improve compliance arrangements for ligature risk reduction, taking into account current and emerging guidance, and best practice	✓ RDASH have in place an annual rolling programme of ligature risk assessments, undertaken by a multi-disciplinary team ✓ Each ligature risk assessment is submitted and reviewed by The Head of Patient Safety. ✓ Each areas have an individual an action plan based on the risk assessment to identify areas which require attention. These are shared with the Head of Estates and the Environmental Risk in Clinical Areas Group to ensure any high-risk areas are followed up swiftly ✓ The Head of Patient Safety monitors the action plans and there is only one action identified as high risk recently that is being addressed ✓ RDASH have commissioned and provided specific training to support the competency of the multi-disciplinary team in undertaking ligature risk assessments ✓ RDASH have devised and circulated a training video on ligature risks to raise awareness across the wider team on understanding ligature risks. This is shared in PMVA training and has been circulated through daily communications ✓ The risk assessment tool in place is based on the Manchester Tool, CQC have raised concern at a national level regarding the use of this tool but have not provided an alternative. The main concern is related to the height levels in that individuals can ligature from low level points. This has been reinforced through additional alerts circulated. 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 the meantime, we have issued all alerts to clinical areas asking them to update their risk assessments to include low level ligature risks and action to be taken. ✓ Specific risk assessments for patients are completed on SystmOne. ✓ A Ligature Task and Finish Group has been established to report to the Environmental Risk in Clinical Areas Group (ERICA). This group considers specifically performance against the rolling programme, action taken to address and mitigate risks and national learning.

Table 1: **Ambition 1: Trust Refreshed Strategy**	
Provide safe and effective care, first time, every time	
Action	**Achievements**
	✓ ERICA reviews all incident of ligature and considers any themes, trends, areas for action on a quarterly basis ✓ The reduced ligature policy is approved and in date
Improve the systematic focus on quality and safety based on national good practice by designing a Trust wide Quality Management System, including rolling out Quality Circles across clinical specialties	✓ Throughout the COVID 19 pandemic Gold Command managed the process and oversight for the Quality Management System. ✓ The Learning Disability Quality Circle is in place and operational
Strengthen Patient Safety Culture by establishing Patient Safety Specialists within our workforce, to lead on safety within their service	✓ Patient Safety Specialist in place ✓ Part of national and local Patient Safety Specialist Networks ✓ PSS leading the roll out of the national patient safety training syllabus which is now embedded into ESR ✓ Patient Safety Champions in place
Work to adapt our safety and quality culture to expand patient safety thinking by expanding the roll out of Safety Huddles and Schwarz Rounds	✓ 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 ✓ Schwartz rounds are in place and the feedback from participants is excellent, highlighting how they are supporting the work of professionals
Improve safe staffing levels on wards by increasing staff recruitment and retention rates of nursing colleagues	On track with following actions in progress: ✓ Monthly Safe Staffing meetings continue to ensure effective line of sight on fill rate and challenges ✓ Safe staffing handbook refreshed including real time escalation process ✓ Workforce development opportunities to support on boarding nurses including international recruitment and the refugee nurse programme ✓ Pilot schemes including 136 suites in Rotherham and North Lincs ✓ Career pathway developments for Non- Registered Nurses
Review caseloads for staff working in the community to inform funding discussions with commissioners	✓ Daily management of staffing with the support of the predicted demand case tool and based on service acuity detailed in the summary section ✓ Progressing with plans to automate the caseload tool ✓ Workforce development opportunities including rotational posts and international recruitment ✓ Introduction of clinical lead posts to improve quality and patient safety and support caseload reviews ✓ Digital transformation in health care is on the community nursing agenda to support maximising flexibility and caseload management ✓ Support maximising capacity, we have focused on proactive caseload management to discharge patients back to their own care, their carers care or the care of a care home.

Table 1: **Ambition 1: Trust Refreshed Strategy**	
Provide safe and effective care, first time, every time	
Action	**Achievements**
Develop an approach to improve the response rate to the Family & Friends Test	✓ Established a Trust-wide working group specifically to develop and improve our Your Opinion Counts process, and to support a relaunch ✓ Refreshed and redesigned both electronic and paper versions of the form, including the planned move to a new software platform, allowing a more sophisticated and intuitive design for patients to use at no additional cost to the Trust. ✓ New questions added around demographics and care episodes to improve the richness and quality of our patient experience data and to ensure we are meeting our responsibilities around patient equality monitoring ✓ We are working with the Trust's deaf service lead to develop a new BSL version of the form, which will be trialled at a Doncaster community event in Q1. We are also working with LD colleagues to refresh the existing Easy Read format. ✓ Working with an external patient experience partner to strategically distribute the survey via SMS text messages, bringing us in line with many fellow provider Trusts regionally and nationally who have successfully obtained high levels of quality feedback this way. ✓ All services are now being requested to include the YOC and/or the FFT question as part of their standard discharge process, including a paper copy and QR code attached to patient discharge letters. ✓ We have opened dedicated social media accounts to publicise the YOC and other surveys/feedback opportunities, including an upcoming campaign for the relaunch.
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) and	✓ Job description developed for Patient Safety Partners ✓ Recruitment process underway for a PSP (May 2022) ✓ Engaging patients and their family's community of practice is being established following a successful Time to Think session held to consider how we can support patient and their families in the SI processes further
Prioritise clinical audit programme to focus on top 6 patient safety issues	✓ 6 key audit programme in place and operational ✓ Each care group has their own nuanced audit programme

2.1.1 Priorities for Improvement 2021/22 and our progress against these

In 2020/21, 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 2: 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.	
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 ✓ Reporting timeframes on incidents and closures are monitored on a monthly basis ✓ We have developed triangulation reports for use in specific circumstances that brings together a range of intelligence data on specific areas ✓ We have continued to develop the Integrated Dashboard and Patient Safety Dashboards to report against key themes and action taken
Fully implementing Tendable by Q4 2021/2022	See Table 1
Fully implementing Oxehealth by Q2 2021/2022	See Table 1
Implementing the new National Reporting and Learning System by Q1 2021/2022	✓ The national timescale for the implementation of the new National Reporting and Learning System has been delayed due to COVID 19. The Trust has confirmed the system it uses internally for reporting incidents is compatible with the new national system and will be ready for implementation when the national system goes live. In the meantime we continue to maintain compliance with the current reporting arrangements.
Undertaking three- year analysis of patient safety incident by Q1 2021/2022	✓ This is underway and will be reported on by the end of May 2022
Undertaking a three-year analysis of serious incident and patient safety incidents, focusing on inequality and diversity by Q1 2022/ 2023.	✓ This is underway and will be reported on by the end of May 2022
Developing a policy for the management of patient safety alerts by Q4 2021/2022	✓ The policy for CAS alerts was reviewed and updated to reflect the national changes regarding safety alerts. This is pending approval by the Clinical Policies Approval Group due by the end of May 2022

Table 3: 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 • 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 • 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.	
Will be achieved by:	Achievements
Developing an organisational learning framework by September 2021	✓ Organisational learning framework in place ✓ Time to think sessions have been implemented ✓ 7 minutes briefings are developed to share learning from serious incidents ✓ Post incident debrief support has been developed and is being rolled out across areas ✓ Trauma Informed Community of Practice is in place and supports how we can support learning further
Development of a patient safety training programme in line with the national syllabus by Q1 2023/2024	✓ Programme developed nationally and RDASH formed part of the national working group ✓ Patient Safety Training is available on ESR in 2022-2023 we will commence performance reporting against it
Development of a patient safety web page including learning from incidents by Q4 2021/2022	✓ Webpage developed which includes: o NHS Patient Safety Strategy o 7-Minute Briefings o Patient Safety Messages o A Just Culture Guide o Patient Safety Incident Response Framework (PSIRF)
Delivery of a medication safety improvement programme by Q2 2023/2024	Will commence in 23/24
Development of an incident reporting system for patients by Q4 2022/2023	Will commence in 22/23
Developing and recruiting patient safety partners by Q4 202/2023 Development of a patient safety partners forum/ focus group Q4 Q2022/2023 that includes Champions and patient safety partners	✓ PFG in place ✓ Recruitment process for PSPs underway ✓ Patient Safety Champions in place ✓ Forum will be developed in 22/23 ✓ Initial discussions commenced with QUIT regional lead on use of volunteers to support smoking cessation
The Patient Safety Specialists will have completed the national training in time scale Q1 2021/2022	✓ Undertaken training as a group of specialists and completed level 1 & 2 of the training
Development of a role's specification for patient safety champions Q4 2021/2022	✓ Template job description produced nationally ✓ Presentation delivered to Trust Board on National Patient Safety Strategy in 2022

Developing a claims plan embedding the learning from the NHS resolution guidance by Q4 2021	✓ A self-assessment will be completed against the national standards and an action plan developed. The development plan will be shared with Quality Committee in July 2022
Developing responding to complaints training for front line staff by Q1 2022/2023	✓ Approved as a pilot site for PHSO standards ✓ Self-assessment completed and presented to Quality Committee ✓ Action plan in place
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.	✓ Approved as a pilot site for PHSO standards ✓ Self-assessment completed and presented to Quality Committee ✓ Action plan in place

Table 4: 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. • 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 • Prioritise clinical audit programme to focus on top six patient safety issues by June 2021.	
Will be achieved by:	Achievements
Scaling up use of NEWS2 across the organisation by Q3 2021/2022	✓ Completed the Trust now uses NEWS2
Development a handbook for leads on managing complaints by Q4 2021/2022	✓ The handbook has been drafted and will be approved by the Serious Incident Group in July 2022
Development of an environmental risk assessment by September 2021	✓ RDASH have developed an environmental risk in clinical areas assessment tool ✓ The tool was piloted on The Brambles in December 20201. ✓ Due to the impact of COVID 19 the pilot of the tool on other inpatient wards was stood down and it was agreed that the Health and Safety Team would complete all inpatient areas by April 2022 ✓ As of 4/5/22 All inpatient areas except 3 areas have had an assessment. The remaining areas identified have dates booked in that had to be changed due to COVID outbreaks/ demands. These have been rearranged.

	✓ A review of the learning from undertaking the environmental risk assessments will take place and be reported through to the Safety and Quality Operational Group to consider how arrangements will be managed after year 1.
Development of ligature risk heat maps to further inform areas of focus in clinical environments by September 2021	✓ Potential solution identified and to be progressed with wards by Patient Safety Specialist by end Q1 2022/23.
Development of an alternative risk assessment tool to the Manchester ligature tool by Q4 2021/2022	✓ 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 the meantime, we have issued all alerts to clinical areas asking them to update their risk assessments to include low level ligature risks and action to be taken.
Developing a restraint reduction strategy by Q4 2021/2022 and agreeing the incident reduction target of 10% for 2022/2023	✓ A consultation event has been held with staff across the Trust to consider how we can further improve safety and reducing incidents of violence and aggression, the results of this consultation have been shared with ERICA and will feed into the strategy being developed ✓ Consultation with patients has been undertaken via survey monkey and specific sessions with RRI Team this feedback will also inform the Strategy being developed ✓ A policy on the Use of Force Act-in place and approved ✓ Information for patients on their rights and expectations regarding the Use of Force disseminated to all clinical areas ✓ A designated responsible person is in place in respect of the Use of Force requirements. ✓ Arrangements in place for reporting of incidents where force has been used ✓ Training for staff is in place and complaint with BILD accreditation ✓ Local research on violence and aggression completed and in final stages of reporting which will inform the strategy development ✓ QUIT embedded across inpatient areas providing support and nicotine replacement to support patient experience and reduce withdrawal from nicotine
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 ensuring a line of sight from floor to Board

Continuing the work of the suicide prevention strategy, and also reducing the number of incidents of self-harm following baseline assessment.	✓ Part of suicide prevention groups at ICS level and at Place base. ✓ Observations Policy implemented and training undertaken ✓ Ligature policy reviewed and updated ✓ Mapped the Trust against 10 Points to Patient Safety. ✓ Introduction of OxeVison to more closely monitor patients and enable immediate identification of concerns with patient. ✓ Tendable implementation ✓ Internal bathroom doors changed across organisation to ensure that they do not provide a ligature point. ✓ Environmental risks 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 ✓ Work around monitoring and management of waiting lists to ensure patients are seen in a timely manner ✓ Single point of contact for each Trust Crisis Team
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	On track to achieve: ✓ Review of the Structured Judgement review process and template in line with Patient Safety agenda with post implementation review planned ✓ Launch of new iPOC- Skin Integrity Impaired Outcomes Pressure Ulcer Risk Assessment ✓ A refresh audit protocol in development and to address health inequality indicators as a measure of quality
Expanding the STOMP and STAMP programme by Q2 2022/2023	✓ We reviewed the Psychiatry Pathway and moved to a more nurse lead home treatment pathway. ✓ We employed a nurse consultant to support the stomp agenda ✓ We have a non-medical prescriber in the team to support the Consultants to embed STOMP ✓ We trained all the clinical teams to use the MOSS-PAS assessments
Demonstrating compliance with Learning Disability Improvement Standards by 2023/2024	✓ To review in 2023/2024 when we can compare the NHS Learning Disability Standards Benchmarking results ✓ We formed a work stream to develop a training package to ensure all staff will receive learning disability awareness training ✓ We have a comprehensive procedure to identify and flag patients with a learning disability

	✓ Annette's Charter has now been published following a serious incident investigation, working closely with the family of Annette. The LD Quality Circle Group will continue to review regularly to ensure that lessons learnt and recommendations are implemented.
Holding an annual patient safety conference by Q1 2022/2023	✓ On target to achieve
Developing and building a Just Culture approach to safety and learning by Q4 2022/2023	✓ Restorative Just Culture training delivered to leaders across the organisation ✓ Cultural intelligence Community of Practice established ✓ Time to think session on Just Culture held ✓ Reflection sessions planned to take forward strategic approach to embedding Just Culture ✓ Handbook for SI leads developed and disseminated ✓ SI leads trained in Just Culture methodology
Developing a Just Culture guide with Human Resources to ensure it is reflected in policies by Q4 2022/2023	✓ As stated above
Delivering training on Just Culture to staff across the organisation by Q4 2022/2023	✓ 28 staff attended the first cohort of training in February 2022. A further cohort is planned for July 2022 with 25 places available for staff.
Implementing a Patient Safety Incident Response Framework by Q4 2022/2023	✓ National roll out of PSIRF delayed ✓ Evaluation of the pilot sites disseminated- report to be presented to Trust Board on key areas of learning and preparedness for the Trust
Reviewing current resources to support implementation of the Patient Safety Incident Response Framework by Q1 2022/2023	✓ In place and work underway
Reducing falls within inpatient services by 10% by the end of 2021/22	✓ Target partially achieved in patient falls reduced by 5% in year
Reviewing and identifying the contributors to patients experiencing frequent falls and reducing the number of patients suffering three or more falls by 10% by the end of 2021/22	✓ Reviewed and contributing factors identified for patients experiencing frequent falls ✓ Falls audits reintroduced in inpatient services ✓ Falls champions for all inpatient areas ✓ Governance structure in place ✓ Training package developed to support inpatient areas out of hours to issue walking aids ✓ Weekly falls report developed and shared with falls champions and falls lead working towards a quality dashboard showing trend analysis Target to reduce number of patients suffering 3 or more falls not met as at end 2021/22. Work will continue to meet this target into 2022/23.
Having a process for safer staffing for community nursing services in place by December 2021, and monitored from December 2021 onwards	✓ Achieved with a template and format reporting to committee that is consistent with inpatient safe staffing process.

	✓ The community nursing teams continue to utilise a caseload tool to monitor demand and capacity and ensure effective redeployment of staffing resources utilising this tool. We continue to progress with automating this tool. ✓ Monthly safe staffing meetings applying the real time escalation principles from inpatient safe staffing ✓ Workforce development opportunities including international recruitment
Refining and improving the safe staffing process and reviews for mental health inpatient settings by September 2021	✓ Refreshed handbook ✓ Monthly safe staffing meetings ✓ Annual report template development and a monthly report template ✓ Revised terms of reference for monthly safe staffing meetings ✓ Continued quality indicators on safe staffing performance dashboard to inform wards on safety and quality
Undertaking clinical audits on the top six patient safety issues and having reports by March 2022.	Please see section 2.2.5

2.1.2 Safety and Quality Priorities for 2022/23

Table 5 below sets out the safety and quality priorities for 2022/23 and how we will achieve this programme in line with the Trust's Strategic Ambition 1: Safe and Effective. This will be a continuation of the priorities set out in 2021/22 and are in line with the 3-year refreshed strategy.

Table 5: Safety and quality priorities for 2022/23
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:
Developing an insight report for each Care Group to further inform patient safety improvement activity by Q1 2022/2023
Further work to develop and strengthen the use of Tendable by Q2 2022/2023
Implementing the new National Reporting and Learning System when it is made live (national implementation delayed in 2021/22 by Covid-19)
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:
Developing and recruiting patient safety partners by Q4 2022/2023
Development of a patient safety training programme in line with the national syllabus by Q1 2023/2024
Further development of a patient safety web page including learning from incidents by Q1 2022/2023
Delivery of a medication safety improvement programme by Q2 2023/2024
Development of an incident reporting system for patients by Q4 2022/2023
Development of a patient safety partners forum/ focus group Q4 Q2022/2023 that includes Champions and patient safety partners
The Patient Safety Specialists will have completed the national training in time scale set by the national team
Developing responding to complaints training for front line staff by Q1 2022/2023

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.

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:

Development a handbook for leads on managing complaints by Q1 2022/2023

Development of ligature risk heat maps to further inform areas of focus in clinical environments by the Patient Safety Specialist by July 2022

Implementation of an alternative risk assessment tool to the Manchester ligature tool, when finalised by the Directors of Nursing Forum.

Developing a restraint reduction strategy and achieving a 10% reduction in incidents by the end of 2022/2023

Publishing a sexual safety charter and agreeing the incident reduction target for 2022/2023

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
- 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

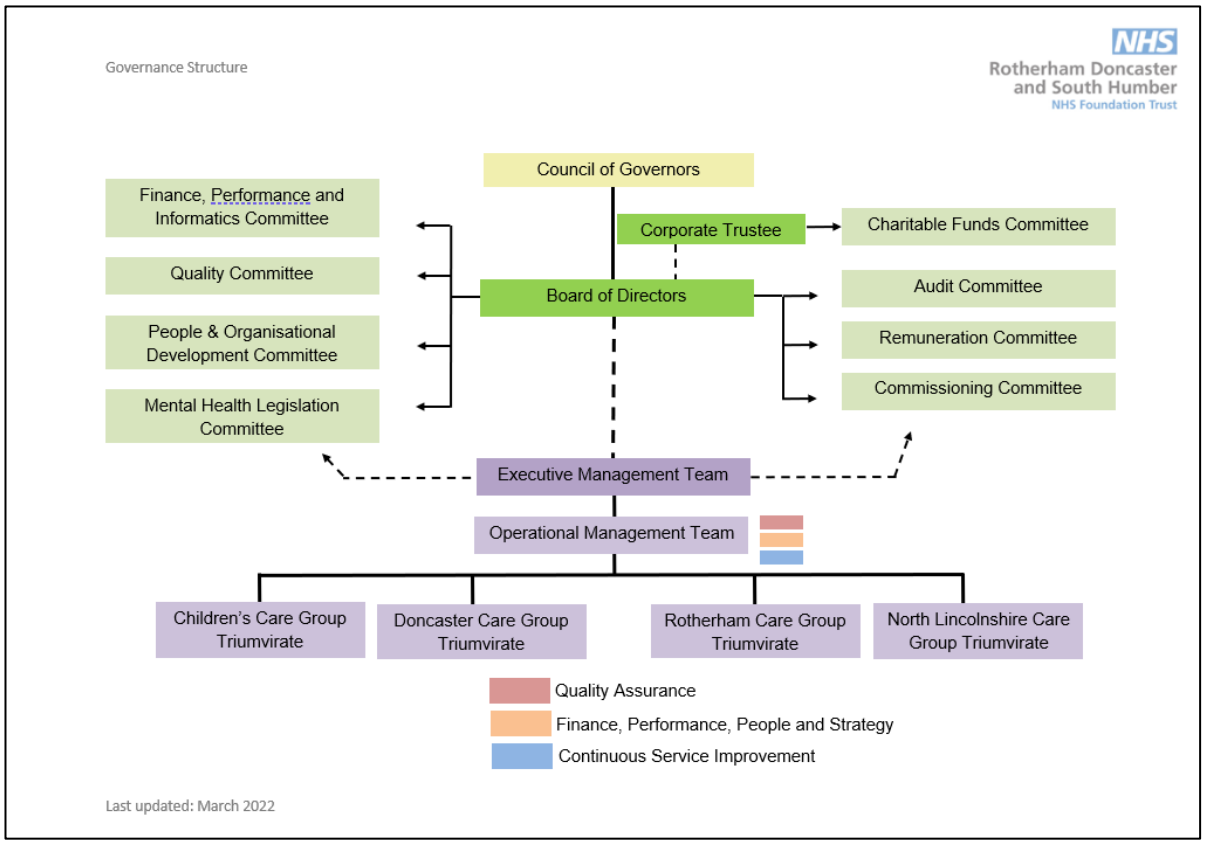
Continuing the Stop the Pressure Campaign to reduce health inequalities relating to pressure ulcers, improved risk assessment and evidence-based intervention by Q2 2022/2023

Expanding the STOMP and STAMP programme by Q2 2022/2023

Demonstrating compliance with Learning Disability Improvement Standards by 2023/2024
Holding an annual patient safety conference by Q3 2022/2023
Developing and building a Just Culture approach to safety and learning by Q4 2022/2023
Developing a Just Culture guide with Human Resources to ensure it is reflected in policies by Q4 2022/2023
Delivering training on Just Culture to staff across the organisation by Q4 2022/2023
Implementing a Patient Safety Response Framework by Q4 2022/2023
Reviewing current resources to support implementation of the Patient Safety Incident Response Framework by Q1 2022/2023
Implementing the national patient safety measurement principles when published Q1 2022/2023 (when national measures for improvement will be set)
Reduce the number of patients suffering three or more falls by 10% by the end of Q2 2022/23.
Continue to monitor safer staffing for community nursing services from December 2021 onwards, including progressing automation of caseload tool and furthering international recruitment opportunities.

2.1.3 Measuring and reporting of the priorities for improvement

The following governance structure is in place:



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

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

Table 6: 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 Clinical Commissioning Group (CCG) • Rotherham CCG and • North Lincolnshire CCG
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 CCG • Rotherham CCG • North Lincolnshire CCG

In addition, 'Quality of care' metrics are also reported as part of the Trust's Integrated Performance Dashboard. These are in line with and additional to the Oversight Framework 2021/22 and have been updated in May 2022 to ensure that the measures are reflective of key areas of learning and priority for the Trust.

Patient engagement and experience is reported quarterly to the Trust Safety and Quality Operation Group, Quality Committee and to the CCGs.

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:

SR2 If the Trust does not promote and support a values-based culture and provide development opportunities then this may impact on the retention and cohesion and on the Trust's ability to provide high quality services.

SR4 If we do not work in collaboration with our people, patients and partners then the Trust may fail to provide integrated, coordinated and quality care that meets the needs of our communities / service users and operate efficiently and effectively within our health economy.

SR5 If the Trust does not recognise and deliver fundamental standards of care then this may impact on patient safety and regulatory requirements.

SR6 If we do not have a robust governance process in place then this may lead to the Trust being ineffective, inefficient and compromise the well-led status of the organisation.

SR7 If a significant destabilizing 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 2021/22 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

Summary Report from Quality Committee 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.

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 because of their inspection and an action plan was subsequently developed to address these.

The Covid-19 pandemic continued to impact on the Trust's ability to deliver on these actions at pace as patient care was prioritised under these exceptional circumstances. Nevertheless, work has continued to progress on delivery of the action plan throughout 2021/22 and most actions are now complete. Progress, closure, and sustainability of the actions is overseen and approved by the Improvement Board.

Regular updates have provided to CQC during 2021/22 through our 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.

CQC prioritised inspections of Trusts during the pandemic on a risk-based approach. As CQC were assured of the Trust's safety and quality, they have not deemed a further inspection to be a priority during 2021/22. 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 2021/22, 360 Assurance (the Trust's Internal Audit service) has reported the following Internal Audits to Audit Committee relating to quality:

Table 7:

Audit	Received	Audit Opinion
Patient Safety – Infection Prevention and Control	August 2021	• Significant Assurance
Patient Flow – Delayed Transfer of Care	November 2021	• Significant Assurance
Medicines Management revisit	February 2022	• Significant Assurance
Data Quality Policy	February 2022	• Significant Assurance
Strategic level Governance	April 2022	Split opinion: • Significant Assurance – Objectives & Reporting • Limited Assurance – Care Group delivery planning
Clinical Effectiveness	May 2022	• Significant 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., Executive Management Team, 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.

2.2 Statements of assurance from the Board

2.2.1 Freedom to Speak Up

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 5 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 and more so through the pandemic.

The trust has established several routes that staff can take to speak up about issues that concern them over the last year we had to adapt to accommodate remote working. We used digital routes through which staff can raise issues via Micro Soft Teams, Zoom and still supporting face to face where social distancing and infection prevention measures used. The normal routes of raising concerns which we've established of staff 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. The 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.

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 concern raised is addressed satisfactorily to all parties. We continue to seek feedback from those that have raised concerns to improve. The feedback we've received demonstrates that people in RDaSH 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 full time post in October 2019 and has been involved in cultural improvement, visible at staff networks and attending team meetings and events across the Trust. During the pandemic the Guardian has continued to engage with staff groups virtually and through using the Trust Publication and Communications.

Throughout the pandemic we have continued to grow our FTSU Champions from across all Core Services. We have thirty FTSU Champions including a Junior Doctor. We are still recruiting more to cover areas across the organisation where reporting is low or non-existent. The new FTSU Champions have received FTSU Champions Training. Since merging the Bullying and Harassment Office role with the FTSU Champions role, we have facilitated Bullying and Harassment Awareness Training to give them tools and skills to have conversations to encourage Civility and Respect amongst colleagues. The roles were merged to avoid confusion for workers and ensure that their "speaking up" is understood and interpreted in the broadest sense: there is no artificial distinction made between 'whistleblowing' and other speaking up activities, or between 'formal' and 'informal' concerns. This enables support for the Trust message that "speaking up" encompasses matters that might be referred to as 'raising concerns', 'complaining', 'raising a grievance' 'raising concerns about bullying' or 'whistleblowing'

The FTSU Guardian has now trained as one of the organisations Safety Huddle Coaches through the Improvement Academy. Safety Huddles have successfully been implemented in across the Organisation. The feedback from staff is that the Safety Huddles have improved communication whilst maintaining consistency, keeping patients and staff safe. Huddles are designed to promote a 'Just Culture' and are short multidisciplinary briefings which includes support staff, held at a predictable 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 undertakes a coproduced self-assessment annually using the guidance published by NHSi and the National Guardians Office and this focusses upon positive practice and areas for development. As part of the assurance, the board have now completed the Reverse mentoring program with the two cohorts, colleagues from the Black, Asian, and Minority Ethnic group and Disabled and Wellbeing Network (DAWN). The feedback session has since taken place and the programme has been positively received by both Mentors and mentees with a request to have this programme cascaded throughout the organisation. The learning from this experience is being carried forward through the Workforce Race Equality Standard (WRES) and Workforce Disability Standard (WDES) Action plan.

FTSU training for Board members and all workforce – The third training package "Follow Up" for senior leaders including the Board of Directors, this final module, Follow Up, has been launched in April to support the development of Freedom to Speak Up as part of the strategic vision for organisations and systems.

Freedom to Speak Up – Progress
We updated our internet and intranet pages to include the updated Whistleblowing Policy after amendments made to reflect the new Director of People and Organisational Development – Nicola Hartley who is the Executive Sponsor for FTSU in the organisation. Freedom to Speak Up e-learning package, in association with Health Education England is available on Electronic Record System (ESR) The first module – Speak Up – is for all workers. The second module, Listen Up, for managers, focuses on listening and understanding the barriers to speaking up. Staff at RDaSH can access this training via (ESR), this training is for all workers, students, as well as volunteers.

The discussions concerning FTSU are also widening in terms of the Trust introduction of Just Culture principles and practices, in the next coming months, we are looking at exploring Just Culture and Civility and implementing updated policy in Civility Respect and Resolution Policy to include No Excuse for Abuse. Twenty six individuals from a cross section of the organization completed the Mersey Care Just Culture Program, the group is set to become Civility Leads in the areas of work and help with implementation of Just Culture within the organization.

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 this has had to be adapted due to not being able to have a market stall for monthly inductions due to restrictions.
- Opportunity to be part of a steering group on how to tackle racism and 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 colleagues working remotely

- Safety Huddles implemented in teams to support patient safety and team safety and wellbeing.
- Targeted events embedding links between FTSU wellbeing effects of the pandemic, promoting staff speaking up about patient safety and staff wellbeing
- 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 Civility at Work, alongside colleagues from NHSI/E and patient safety teams
- As an organisation we have extended the FTSU Champion role to our Peer Partnership colleagues at PFG, two peers are training as "Champions of Speaking Up" to promote open culture and learning from peers.
- The FTSU Guardians had the opportunity to share our RDaSH FTSU Journey at a Regional Wellbeing virtual festival event and at NHS Careers Event ant local Universities to encourage student voices.

Adopting and implementing FTSU in this way has yielded several benefits for patients, staff, and joint working. Key achievements over 2021/22 have been:

1. Focussed work between the Patient Safety Team and the Improvement Team on the importance of early reporting incidents, 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 index.
3. Facilitating Leadership Support Circles and REACT, these support staff with psychological wellbeing which has 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 during the pandemic.
6. Introducing and planning the next stage of Restorative Just Culture at RDaSH, collaborating with several stake holders 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, Sharing learning from other organisations.

In 2021/22, the Trust received 33 FTSU concerns. There are more FTSU Champions in the organisation – 40 that work across the trust. This has helped in staff being able to raise concerns directly within their care groups. The National Guardian Office has issued new ways for cases to be recorded including those that go through FTSU Champions this may help bring the figures back up to what we've previously reported in the past.

2.2.2 Staffing in the adult and older adult community mental health services

Despite the ongoing operational and planning pressures arising from the pandemic, 2021/22 saw some significant mental health service development activity across the Trust which impacted positively the provision of care and treatment. Key Clinical Commissioning Group investment into staffing in community mental health services in 2021/22 was as follows:

Doncaster

- £81,000 for perinatal mental health services
- £398,000 Service Development Funding (SDF) for adult mental health community and crisis services including £325,000 for mental health Additional Roles Reimbursement Scheme (ARRS) roles

- £112,000 for 18 – 25-year-olds services
- £140,500 for children and young people's (CYP) Community Eating Disorder (CEDs) services
- £654,500 for Mental Health Support Teams (MHST) in schools
- £627,000 SDF and Spending Review (SR) funding for CYP community and crisis services including

Rotherham

- £40,000 funding for perinatal mental health services, noting that was a part year effect and will rise to £199,800 in 2022/23
- £102,000 funding for Early Interventions in Psychosis (EIP)
- £82,500 for psychology
- £220,000 for adult attention deficit hyperactivity disorder (ADHD) and Autistic Spectrum Disorder (ASD) services
- £154,000 for mental health ARRS roles
- £123,700 for CYP CED services
- £54,900 for MHST in schools
- £399,200 SDF and SR funding for CYP community and crisis services

North Lincolnshire

- £41,700 for Individual Placement and Support (IPS) for people with severe mental illness (SMI) – topped up from the part year effect funding in 2020/21
- £297,000 for Core 24 acute hospital liaison – also topped up from the part year effect funding in 2020/21
- £65,100 for adult ASD services
- £156,000 SDF funding for ARRS roles
- £94,000 for CYP CED services
- £59,000 for MHST in schools
- £46,500 SDF and SR funding for CYP community and crisis services

As part of the national requirement to continue to increase the number of people accessing IAPT for support with common mental health problems, the Trust also received a total of £614,500 extra funding into its IAPT service (£179,000 in Doncaster, £118,500 in Rotherham and £317,000 in North Lincolnshire) to continue to expand the workforce including creating new trainee roles.

Perhaps most excitingly, 2020/21 saw the Trust launch its ambitious Community Mental Health Transformation programme, supported by £552,400 funding in Doncaster, £444,700 in Rotherham and £178,000 in North Lincolnshire. This three-year programme will radically change and improve the way people with mental health needs are supported in the community, delivering improved clinical pathways, putting people's needs at the heart of how care is provided and removing the gap between primary and secondary care.

As can be seen, 2020/21 investment supported service expansion and the development of new roles across a range of services areas, to meet growing demand and gaps in existing services and to improve patient experience and outcomes including the prevention of mental ill health.

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 four standards concern:

1. Respecting and protecting rights
2. Inclusion and engagement
3. Workforce

4. Specialist learning disability services

The Trust is reviewing both its learning disability and its autism services against these standards and has submitted data for national benchmarking.

A Learning Disability Quality Circle is in place, and this is a key forum in ensuring that RDaSH Learning Disability services have a collective voice which informs best practice and supports the continuous improvement of services.

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 Review of Services

During 2020/21 Rotherham Doncaster and South Humber NHS Foundation Trust provided and/or sub-contracted 56 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 56 of these relevant health services.

The income generated by the relevant health services reviewed in 2021/22 represents 100% of the total income generated from the provision of relevant health services by Rotherham Doncaster and South Humber NHS Foundation Trust for 2021/22.

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/

2.2.5 Clinical Audit

National Clinical Audits and Confidential Enquiries

- Rotherham Doncaster and South Humber NHS Foundation Trust participate in national clinical audits identified on the national directory which have key national priorities applicable to Rotherham Doncaster and South Humber NHS Foundation Trust.

- During 2021/22 the Trust participated in the National Clinical Audit of Psychosis (NCAP) including separate case note audits and a spotlight audit on employment. In addition, we contributed to the national Prescribing Observatory for Mental Health (POMH) audits covering *Prescribing for substance misuse: alcohol detoxification* and *Use of Clozapine* and the National Audit of Inpatient Falls (NAIF).

- The Audit team received confirmation in January 2022 of the proposed annual Clinical Audit programme for 2022/23 and this activity has been built into the new Clinical Audit Framework, along with our 6 Key Trustwide Audits and tailored local programmes.

Trust (local) Clinical Audits

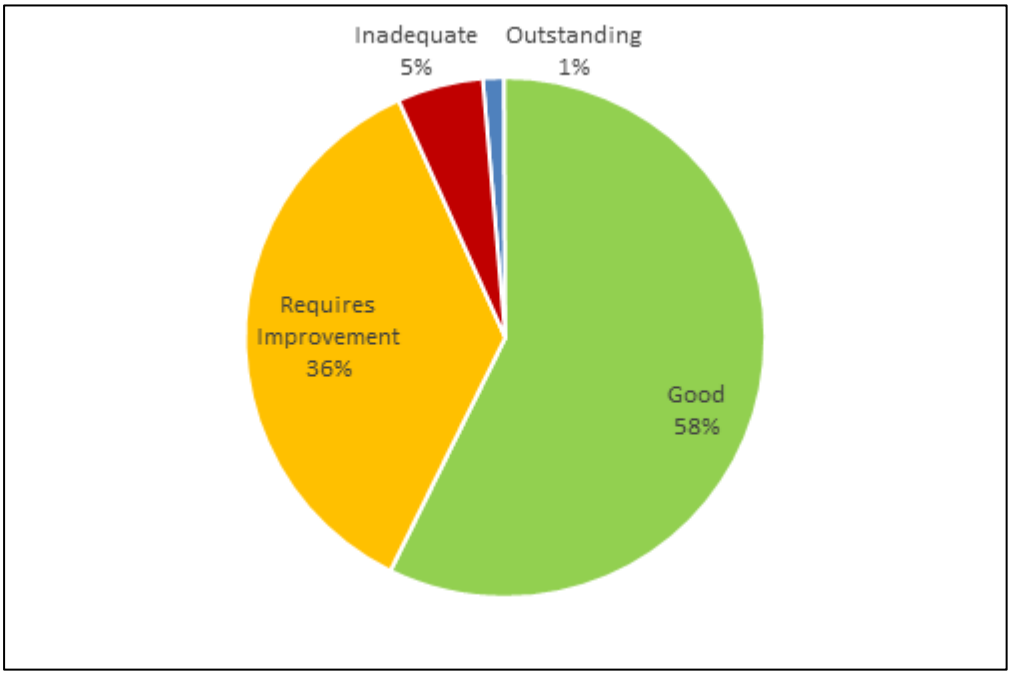
As the end of 2021/22 the status of the audits on the Programme was as follows:

Table 8: Status of Trust Clinical Audits as at end 2021/22	
Data collection underway	9 (8%)
Data collection complete – analysis in progress/report being drafted	4 (3%)
Audit Complete* *This includes 11 audits which are complete but awaiting action planning/approval	106 (89%)

The results of each audit are reported and analysed by the Clinical Effectiveness Team and shared with Care Groups through their Audit Leads and Quality Meetings, as well as with subject-specific forums. Action plans are developed collectively in each case and progress against these actions is tracked centrally by the Audit Team.

The transition to the new Audit Framework has included reviewing current activity and identifying areas where audits can be consolidated and streamlined, making the learning from audit clearer to see. As part of the transition, some activity has also been incorporated into the new Programme.

Of the audits completed during the Programme, the breakdown of outcomes was as follows:



Brief highlights include:

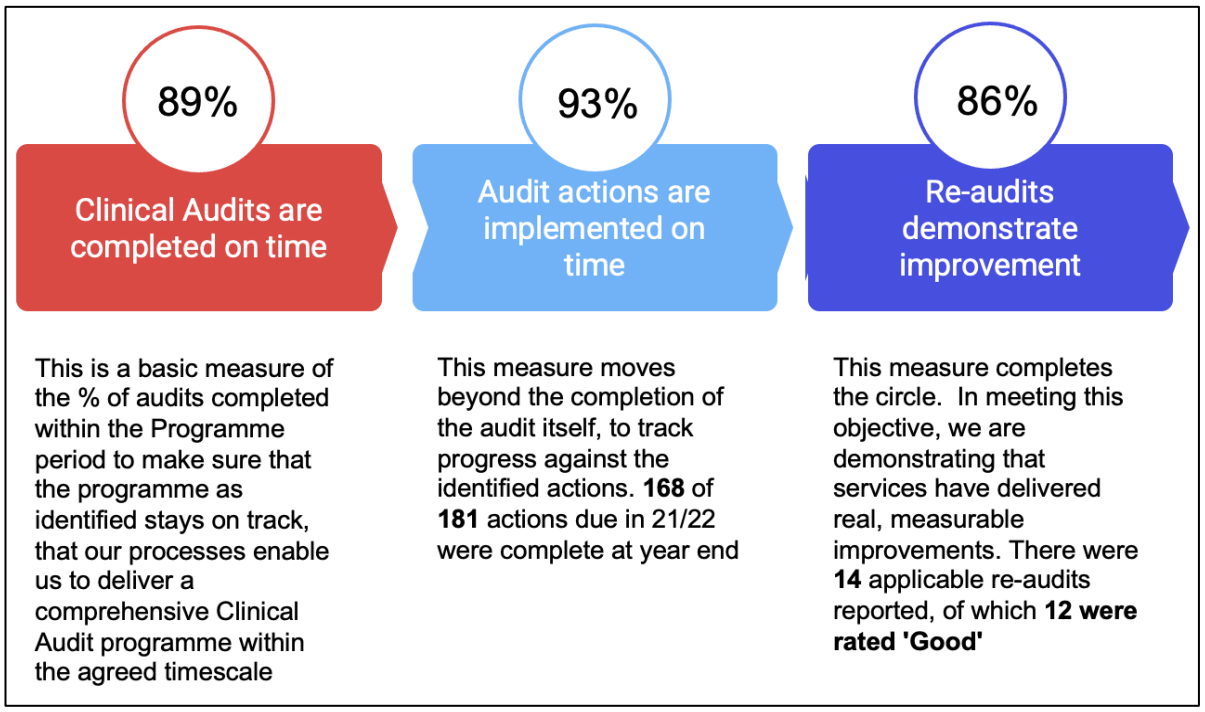
- MUST (Malnutrition Universal Screening Tool) Audit in Doncaster, which moved from Inadequate to Good within the Programme period

- National Clinical Audit of Psychosis (NCAP), in which all Care Groups improved their scores, with Doncaster and Rotherham both being rated as 'Top Performing'

Both topics clearly demonstrate the impact and effectiveness of the audit cycle.

The Care Records/Clinical Risk Assessment & Management Policy Audit represents an ongoing improvement opportunity, with all Care Groups being rated as 'Requires Improvement'. Assessment, Care Planning and Record Keeping has been identified as a specific workstream in the Trust's CQC Action Plan, with 16 of 22 actions already completed and ongoing monitoring established. In addition, the Trust-wide audit already underway will be completed alongside the Programme in 22/23.

In the Trust's refreshed Strategy, three new specific objectives in relation to audit were identified, and 2021/22 has been used to establish our baseline position against them.



2.2.6 Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Rotherham Doncaster and South Humber NHS Foundation Trust in 2021/22 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 1194 against a target of 600 and a stretch target of 800 participants in the NIHR portfolio studies.

2.2.7 Commissioning for Quality and Innovation (CQUIN)

The requirement for the Trust to achieve quality improvement and innovation targets / goals for 2021/22, was suspended because of the Coronavirus pandemic. This meant that the Trust automatically received the CQUIN payment, equivalent to 1.25% of NHS contracts, in 2021/22.

Further details of the original National CQUIN schemes for 2021/22 are available electronically via the NHS England web page at: https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/

2.2.8 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.

CQC conducted a 'Well Led' inspection at the Trust; with unannounced visits taking place in October 2019 and the inspection was undertaken 11-12 November 2019. The inspection report was published on 21 February 2020 with an overall rating of Requires Improvement. This report can be found at http://www.cqc.org.uk/provider/RXE

2.2.9 Data Quality

Hospital Episode Statistics

Rotherham Doncaster and South Humber NHS Foundation Trust submitted records during 2021/22 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 2020/21 and expect to achieve 'Standard Met' for the 2021/22 final submission in June 2022.

Payment by Results

Rotherham Doncaster and South Humber NHS Foundation Trust were paid on a block basis for 21/22 and therefor were not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

Data Quality

During 2021/22 Rotherham Doncaster and South Humber NHS Foundation Trust completed the following action to improve data quality.

- **Internal Review, Sampling & Validation**

Annual data quality programme completed validation for (EIP) Early Intervention Psychosis, (OAP) Out of Area Placement and 72hr follow-up for 2021/22 period, noting some significant improvements and areas for further support.

- **Data Quality Reporting & Supportive Action**

The Trust continues to develop and improve data quality reporting, collaboratively working with services to ensure effective data quality reporting, monitoring, identification, and proactive action. Improved access and central visual representation of clinical caseloads and supporting activity via Business Intelligence dashboards, enabling focused monitoring and process improvement across services. During 2021/22 an audit was carried out regarding the implementation of the Data quality policy. This received significant assurance.

- **Business Intelligence & Data Warehouse Developments**

Following on from the deployment of improved analytical dashboards, the Trust continues positively with Business Intelligence and Data Quality maturity position, whilst maintaining a centralised, integrated and robust approach. The Trusts commitment to continuous improvement and supportive change culture continue to support a positive (DQMI) Data Quality Maturity Index position for 2021/22 whilst supporting improved clinical record keeping and compliance.

2.2.10 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 Deputy Medical Director 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 2021/22 there were 738 deaths reported on the Rotherham, Doncaster, and South Humber NHS Foundation Trust mortality Ulysses system.

This figure relates to deaths of patients from 1 April 2021 to 31 March 2022 who had contact with the Trust within 6 months prior to death.

Of the 738 deaths the following occurred per quarter of that reporting period:

- 176 in quarter 1 (April to June 2021)
- 200 in quarter 2 (July to September 2021)
- 181 in quarter 3 (October to December 2021)
- 181 in quarter 4 (January to March 2022)

Of the 738 deaths, 36 were deaths where Covid 19 was a causal or contributory factor (in 2020/21 there were compared to 164 deaths).

Of these 36, 3 were deaths that occurred in an RDaSH bed and were reported onto the national Covid-19 Central Patient Notification System (CPNS) system. All 3 are subject to a Structured Judgment Review.

- 0 in quarter 1 (April to June 2021)
- 4 in quarter 2 (July to September 2021)
- 17 in quarter 3 (October to December 2021)
- 15 in quarter 4 (January to March 2022)

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 9: SJRs and SI reviews undertaken 2021/22

Quarter	No of deaths	No of deaths reviewed in MOG	No of SJRs indicated from deaths that occurred in the month
Quarter 1	176	176	27
Quarter 2	200	200	31
Quarter 3	181	181	23
Quarter 4	181	181	14
Total	**738**	**738**	**95**

Of all deaths reviewed in MOG, 13% 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:

- Teams displayed tenacity and a solution-based approach to support patients
- Flexible and compassionate patient management
- Good communication with other services to ensure a consistent approach of care and support.
- Collaborative working between Inpatients, community services and the Home Treatment Team.
- Repatriation back to local area done in a timely manner to promote continuity of care.
- Referral rather than signposting done to Drug and Alcohol services to try and promote
- engagement
- Recognition of the impact of Covid 19 on families and the need to do things differently – an example two Psychiatrists who because of covid were unable to get CT scans for diagnosis of dementia but carried out video calls with families allowing discussion, questions and gave a differential diagnosis.
- Families were an integral part of the patients care in the Hospice and there was evidence of steps being taken to ensure that they were able to maintain a caring role if they wished.
- The Hospice worked with families to try and facilitate communication and contact with their loved ones during a very difficult time. They undertook phone calls, used technology, and facilitated garden visits as well as face to face when this was allowed alongside maintaining the safety of other patients and staff.
- In mental health a family had chosen for their relative to remain on the older people's mental health ward at the end of their life. Staff took steps to remove all 'hospital' type items from the room and ensured that the person was surrounded by their personal items, photographs and importantly their family.

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

- The need to ensure that referral information is fit for purpose and includes all the necessary
- information for all potential admissions to the RDaSH bed bases including medical/physical health
- management
- The importance of liaison with other agencies such as Drug and Alcohol services to involve them in reviews especially discharge planning
- Need to strengthen communication with general hospitals to ensure handover of robust Communication
- The need to engage with and provide information for families and carers especially within inpatient services.

Learning from Inquests:

- The Trust has improved its coordination of the Planned and Unplanned Care nursing activity as. Ensuring there are systems and processes in place to formally transfer care from one team to another using an internal electronic referral process.
- Contact emails for each of the crisis areas in 10 neighbouring trusts have been obtained to allow the Trust to send assessments via secure email with a delivery and read receipt when they are completed. This may be during the night and ensures prompt sharing of any necessary information.
- The need for communication between Crisis and IAPT services if a patient is seen by the Crisis team

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 planned in looking closer at specific areas such as locations which will be done in partnership with Public Health
- Undertaken an initial review of Learning Disability deaths against some of the demographic findings from the Annual Report of the English Learning Disabilities Mortality Review (LeDer) programme and the November 2020 University of Bristol report into the deaths of people with a learning disability at the start of the COVID-19 pandemic.
- 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.

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 26 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. We are required by the existing guidance from NHS England to include these in the Quality Report (*'Detailed requirements for quality reports 2019/20, February 2020'*). It is recognised that the data for tables 10 and 11 has not been available for 2 years; however, as no new guidance has been received, these are still included in this report.

Data submissions were suspended due to Covid-19 and data is only available up to Q3 2019/20.

Table 10: The percentage of patients on Care Programme Approach (CPA) who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.

The percentage of patients on CPA who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.			
Indicator	**2019/20**	**2020/21**	**2021/22**
RDaSH *Source: NHS Digital*	98.4%*	Not available as suspended	Not available as suspended
All England highest/lowest Source: NHS Digital	96.7%/89.0%*	Not available as suspended	Not available as suspended
All England Average *Source: NHS Digital*	95.5%*	Not available as suspended	Not available as suspended

** Data submissions were suspended due to Covid-19 and, as at 1/7/20, data is only available up to Q3 2019/20.*

Source: NHS England https://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community- teams-activity/

The Rotherham Doncaster and South Humber NHS Foundation Trust has consistently achieved the 95% target and the compliance has improved from last year.

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 11: The percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period.

The percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period.			
Indicator	**2019/20**	**2020/21**	**2021/22**
RDaSH *Source: NHS Digital*	99.1%*	Not available as suspended	Not available as suspended
All England highest/lowest *Source: NHS Digital*	100%/94.0%*	Not available as suspended	Not available as suspended
All England Average *Source: NHS Digital*	97.1%*	Not available as suspended	Not available as suspended

** Data submissions were suspended due to Covid-19 and, as at 1/7/20, data is only available up to Q3 2019/20.*

Source: NHS England https://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community- teams-activity/

The Rotherham Doncaster and South Humber NHS Foundation Trust has performed consistently high against this metric and the 95% target, delivering a year-on-year improvement.

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
Number of patients readmitted to hospital within 28 days of being discharged aged 0-15	0	0	0
Number of patients readmitted to hospital within 28 days of being discharged aged 16 and over	92	50	36

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	Average Trust Score England 2021
In the last 12 months do you feel you have seen NHS mental health services often enough for your needs?	64%	65%	60%	59%
Were you involved as much as you wanted to be in agreeing what care you will receive?	72%	78.3	85%	83%
Were the person or people you have seen most recently aware of your treatment history?	72%	75.7	71%	68%

Source: CQC Mental Health Community Services Survey 2021

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 2021 contacted 1250 service users, of which 301 went on to take part. The full report was received in August 2021 and a summary of the findings and recommendations were shared through the Patient Experience Report with the Safety and Quality Group in October and Quality Committee in November. In comparison with other Trusts the results for specific questions for RDaSH are categorised depending on whether they are 'better', 'worse' or 'about the same'. For RDaSH the breakdown was as follows:

'About the Same' – 25 questions
'Better than Expected' – 2 questions
'Much Better than Expected' – 1 question

The overall patient satisfaction outcomes saw 25% of patients score their experience with RDaSH as 10 (out of 10), compared with a national average of 19%.

In 6 categories, RDaSH were in the top 20% of Trusts. These categories suggest that patients on the whole felt

- clear about who to contact with any concerns of questions
- included in decision-making about their care
- well-informed in terms of medication
- supported to get the help they needed

No scores were in the bottom 20% of Trusts, but the single worst score was in response to the question '*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?'* On this question, RDaSH scored 2.9% below the national average.

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.	%	
2021/22									
Apr 21 – Mar 22	5194	*	*	13	0.2%	*	18	0.3%	*
2020/21									
Apr 20 – Mar 21	4006	48.6	*	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%	0% - 4%	3	0.1	0% - 2.5%

Source: National Reporting and Learning System (NRLS)
NHS England » Organisation patient safety incident reports

*NHS England will publish data for April 21- March 22 in September 22

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 identifying themes and trends, and so maintain the quality of its services, by creating a culture of openness and a restorative just culture enabling staff to feel able and confident to report incidents without fear of reprisal.

2.4 Performance against indicators set out in the Oversight Framework

Table 15 shows our performance against the indicators which are monitored by NHS Improvement, as required for our regulation processes and set out in the Oversight Framework (OF).

Table 15: Performance against OF indicators

Targets	Target 2021/22	2020/21	2021/22
Early intervention in Psychosis (EIP): People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral.	56%	96%	92%
Data Quality Maturity Index (DQMI) MHSDS dataset score	95%	96%	96%
Improving access to psychological therapies (IAPT):			
a) Proportion of people completing treatment who move from recovery (IAPT dataset)	50%	52%	50%
b) Waiting time to begin treatment (from IAPT minimum dataset) within 6 weeks of referral	75%	93%	94%
c) Waiting to begin treatment (from IAPT minimum dataset) within 18 weeks of referral	95%	99%	99%
Number of people entering treatment with anxiety or depression	17720	12573	16784
Care programme approach follow up: proportion of discharges from hospital followed up within 7 days	See Table 12 (section 2.3)		
Admissions to adult facilities of patients under 16 years old	0	0	0

Targets	Target 2021/22	2020/21	2021/22
Inappropriate out-of-area bed days for adult mental health services (average per month) [B]	<1157	2199	3385
Source: RDaSH performance reports			

[B] *Inappropriate out-of-area bed days for adult mental health services (average per month): the guidance states:*

- *The indicator should be presented as a 'number per month'. The disclosure should be based on performance for the year; therefore, the figure presented will be the average of the 12 monthly figures for number of bed days per month.*
- *Where the figure for disclosure is between 1 and 7 (as average per month for the year), the foundation trust should disclose no figure, and state that it is not required to disclose performance where it has 7 or fewer average bed days per month.*

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

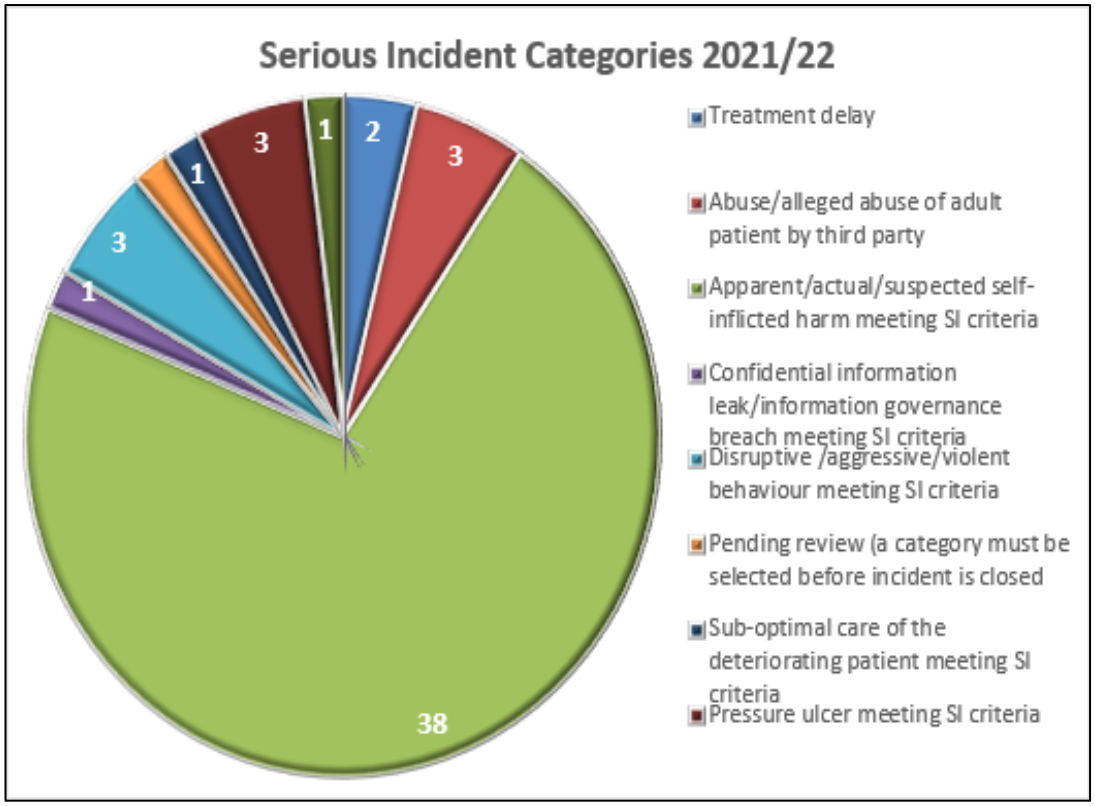
3.1.1 Serious incidents: see also Section 2.3 Table 15 for reporting against core indicators regarding patient safety incidents

- **SIs reported**

Of the total number of incidents reported in 2021/22 54 serious incident investigations were commenced in 2021/22, an increase of 13 (42%) from the previous year.

Table 16: SIs	2019/20	2020/21	2021/22
Total number of SIs reported for the financial year	59	41	54
Total number of SI investigations submitted to date	53	51	46

- **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

- **Learning from SIs**

The learning from SIs is shared in a number of ways

Examples of learning from SIs in 2021/22:

- Long-term involvement with patients over several years previously has created a dependency upon some of the Trust’s Mental Health Services. Isolation from the effects of COVID has added to the stressors of those individuals who are already suffering from mental health issues and whose support network has reduced or ceased.
- Admissions to in patient environments can escalate risk taking behaviours and the ongoing 24-hour presence of staff and the care provided can result in a patient relinquishing responsibility for their behaviours and transferring this responsibility on to the staff.

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

- Development of learning with our organisation learning framework
- Continue with developing our patient story video’s to be shared widely
- Develop new way of communicating learning using all types of media

- **Key achievements in 2021/22**

    - Maintained a high quality and performance in investigating serious incidents during the pandemic
    - Adapted to new ways of working and the challenges the pandemic created in undertaking investigations
    - Expanded our bank of investigators to strengthen knowledge and experience in the Patient Safety Team
    - Undertaken analysis of incidents identifying themes and trends as part of working towards the new Patient Safety Investigation Framework

3.1.2 Safeguarding

NHS Trusts have a responsibility to ensure that the agreed standards for Section 11 of the Children Act 2004 are met, and that they comply with statutory guidance outlined in Working Together to Safeguard Children 2018. The Care Act 2014 puts adult safeguarding on a legal footing and all healthcare staff have a duty to raise concerns about abuse or neglect of adults at risk. Staff working directly with children must ensure that safeguarding forms an integral part of all stages of care they offer. All professionals also need to note that when they are not working directly with a child but may be seeing their parent, carer, or significant adult that they have a responsibility to safeguard and promote the welfare of any child or young person and adult.

RDaSH 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.

As part of demonstrating its commitment to meeting the arrangements described above, the Trust completes three annual self-declarations for each of the local Clinical Commissioning Groups, and assessments and inspections requested and required by Local Safeguarding Children Partnerships and Safeguarding Adults Boards to demonstrate compliance with duties outlined by Section 11 of the Children Act (2004) and the Care Act 2014.

The Trust has a safeguarding manual which contains safeguarding policies and guidance around 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.

Training

All staff within the Trust are aligned to the level of safeguarding 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).

RDaSH uses a blended learning approach to achieve compliance with level 3 safeguarding training. All training meets national standards as described in the Intercollegiate documents. Prior to the onset of the Covid-19 pandemic, all safeguarding training was delivered by means of face-to-face group sessions. However, adjustments were made to enable the training to continue virtually via MS Teams. This method of delivery has been successful,

with additional benefits of increased number of participants and positive feedback for the new format.

Bespoke training has been developed in response to local need, for example, non-accidental injuries to children training has been developed following the learning from a Safeguarding Child Practice Review.

The Trust contributes to the delivery of multi-agency training programme developed by the Local Safeguarding Children's partnerships and Safeguarding Adults Boards.

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. RDaSH 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 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 continues to be 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 have a continued commitment to promoting best practice in infection prevention and control and to maintain our long held low incidents of healthcare associated infections within the Trust.

We must acknowledge that this reporting period has been unlike any other with the COVID-19 incident response requiring us to work in different ways, respond to significant and unprecedented IPC challenges. We are proud as an organisation to have stepped up to this challenge and supported our patients and staff and partners in a robust response.

We have delivered on the Trust-wide IPC Compliance Standards Implementation Work Plan which is also linked to the organisation's 2021/22 ambitions.

The IPC Team, Care Groups and Corporate Services work in close partnership to provide strong leadership and support, ensuring compliance against guidance and legislation relating to the prevention and management of infections.

Table 17: Notifications of Mandatory Healthcare Associated Infections

Indicator	2019/20	2020/21	2021/22
Escherichia coli (E. coli) bacteraemia	3	0	0
Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia	0	0	0
Meticillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemia	0	1	0
Clostridium *difficile* infection (CDI)	3	3	2
Source: Local Reporting System, cases as defined by Health Protection Agency Guidelines			

- **CDI**

There were 2 cases of CDI in Doncaster Care Group on Hawthorn ward. The Post Infection Review (PIR) process identified both cases had received multiple courses of antibiotics which was a contributory factor however there were lessons learnt:

  - Case 1: there were gaps in patient records as to why a specimen was obtained when no loose stools were recorded
  - Case 2: there were missed opportunities for obtaining samples and inappropriate bed movement whilst patient was still symptomatic due to miscommunication between ward staff

Action plans have been formulated and progress against the plan reviewed at clinical visits.

- There have been 0 outbreaks of Norovirus or Influenza Trust wide.
- There have been 21 outbreaks of COVID-19 across the Trust.

- **Areas of Achievement**

In the past 2 years the management of the COVID-19 pandemic has been the single greatest public health emergency in the history of the NHS and the challenges faced by the Trust in implementing effective IPC precautions cannot be underestimated.

Under the effective leadership of Gold Command, the Trust rose to the challenge and effective systems and process were put in place to manage outbreaks of COVID-19 infection. Outbreak Control Group meetings were convened for all outbreaks and a co-ordinated approach to managing these incidents was undertaken to prioritise staff and patient safety.

Despite the increased workload associated with the management of the pandemic, the following IPC workstreams continued to be delivered:

  - The IPC Team have maintained a proactive approach with the emphasis on being visible and approachable, particularly ensuring that expert advice and support could be readily accessed by all staff across the Trust. They have been resilient throughout and flexible in their approach including occasional out of hours support during peaks of intense activity and high case numbers.
  - Completion of the Trust wide IPC Compliance Standards Implementation Work Plan

- IPC audits undertaken in all 19 in-patient areas. Support provided to ward staff to develop robust action plans to address areas of non-compliance.
- Community spot checks completed in 14 premises
- Continued increase in the number of completed Healthcare Associated Admission Risk Assessments forms
- The ongoing collaborative work with the Estates and Facilities Team to ensure high standards of cleanliness and keep our water systems safe. Reconfiguration of the Trust Water Safety Group to include IPC membership as well as establishment of a Ventilation Group to comply with new guidance issued highlighting problems with old and outdated facilities
- Review and update of 16 procedures in the IPC manual
- 360 Assurance Review undertaken with an overall conclusion of significant assurance was given, this being the highest level attainable.

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 2021/22 to reduce the number of expired policies requiring review, from 23 in April 2021 to 13 in April 2022. The Clinical Effectiveness Team have successfully provided an increased level of support to Policy Authors and Owners.

To build on this progress, the Deputy Director of Safety and Quality is leading on a piece of work to

- 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 opportunities that this element of work feeds into the transformation started as part of the last CQC inspection
- Consider how the approach regarding clinical policies can dovetail with Corporate polices.

3.2.2 NICE quality standards

In 2021/22 the Trust has developed, piloted and implemented a new centralised process for reviewing, updating and recording compliance with NICE Guidance, with significant benefits in reducing duplication and clinical time spent by NICE leads, review and dissemination of guidance, addressing historical assurance gaps and helping to support the transition from HealthAssure for recording compliance.

The NICE Guidance centralised meeting has provided the care group NICE Leads with the opportunity to discuss and agree the NICE guidance that is applicable across the whole organisation, including corporate services

The pilot has highlighted the following benefits:

- More timely review of NICE guidance from an organisational perspective. As a result of the NICE centralised process and the administration support, we now have a full trust wide compliance position against NICE guidance within 28 days.
- Greater consistency in relation to how NICE guidance is assessed and implemented across the services and diverse footprint that RDaSH provides, avoiding duplication of clinical effort in reviewing separately and a unified Trust position.
- The evaluation of the pilot identified a cost saving in terms of senior clinicians' time spent on administrative duties for individual review and updating of HealthAssure (North Lincolnshire & Rotherham), is £21,392 per annum.
- A reduction in the backlog of NICE guidance reviews across the Trust, with for example, in N Lincs a reduction from 457 individual pieces of guidance outside of 28 days to review, down to 0 currently.

The new centralised process has been supported by additional recruitment of administrative support.

The Trust is also moving away from using HealthAssure in October 2022, creating a new in-house system for recording and tracking compliance.

3.3 Patient Experience

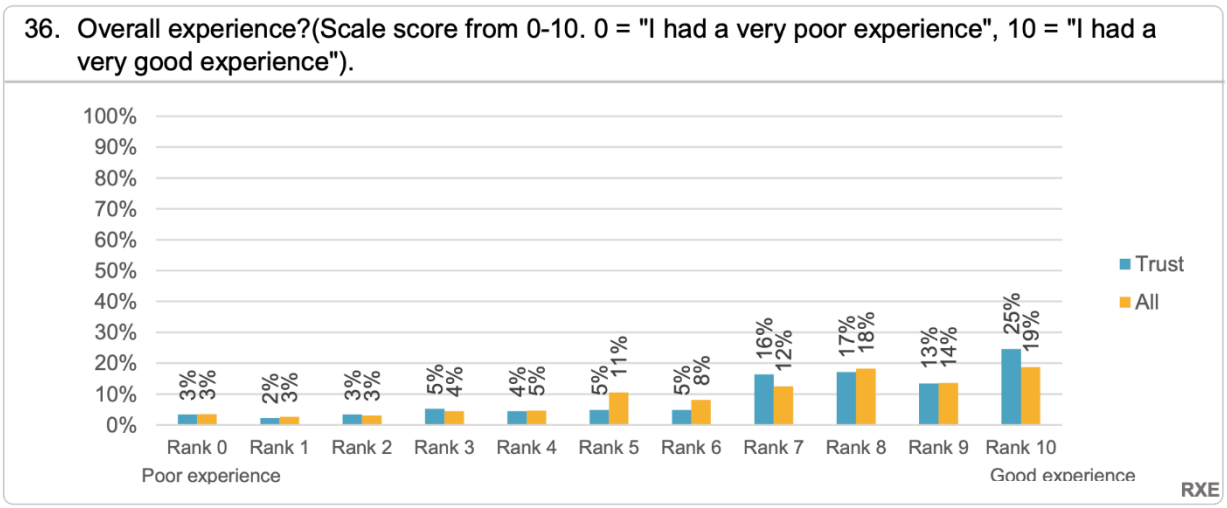
3.3.1 Community Mental Health Survey

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.

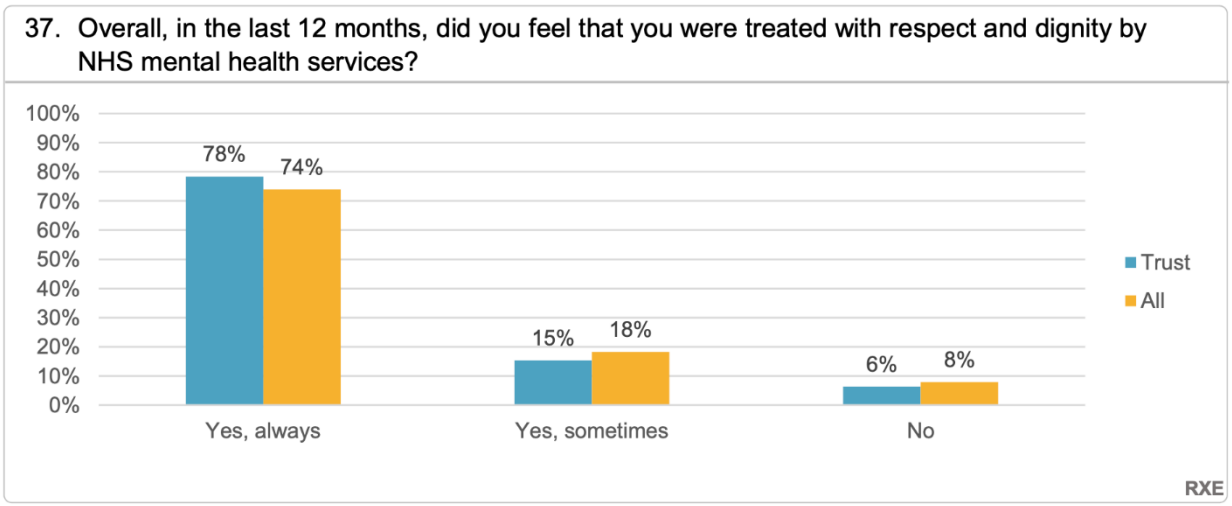
RDaSH took part in the survey in 2021, with 304 patients providing feedback. For each scored question in the survey, the individual (standardised) responses are converted into scores on a scale from 0% to 100%. A score of 100% represents the best possible response and a score of 0% the worst. The higher 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 6 scores in the top 20% range and no scores in the lower 20% range.

The overall patient satisfaction outcomes saw 25% of patients score their experience with RDaSH as 10 (out of 10), compared with a national average of 19%.



Patients also reported a positive experience of respect and dignity, with 78% reporting a good experience 'always' and only 6% responding 'no', again above the national average.



The 6 areas where RDaSH performed most strongly were as follows:

Table 18 : 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
Q10: Have you been told who is in charge of organising your care and services?	62%	68%	77%	91%	249	78.1%	
Q12: Do you know how to contact this person if you have a concern about your care?	94%	95%	98%	99%	192	98.8%	
Q18: Did you feel that decisions were made together by you and the person you saw during this discussion?	71%	75%	81%	84%	188	81.9%	
Q20: Thinking about the last time you tried to contact this person or team, did you get the help you needed?	51%	62%	70%	74%	150	70.9%	
Q23: Have the possible side effects of your medicines ever been discussed with you?	52%	55%	61%	68%	247	67.6%	

Q26: In the last 12 months, has an NHS mental health worker checked with you about how you are getting on with your medicines?	67%	72%	79%	86%	209	81.0%	

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

- clear about who to contact with any concerns of questions
- included in decision-making about their care
- well-informed in terms of medication
- supported to get the help they needed

Whilst there were no questions that fell below the lower 20% benchmark threshold, the five questions with the lowest overall scores were as follows:

Table 19 : Bottom 5 questions	**Score**
Q38: Aside from in this questionnaire, in the last 12 months, have you been asked by NHS mental health services to give you views on the quality of your care?	16.4%
Q34: 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)?	41.8%
Q33: In the last 12 months, did NHS mental health services give you any help with finding support for financial advice or benefits?	43.4%
Q32: In the last 12 months, did NHS mental health services support you with your physical health needs?	49.4%
Q3: In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs?	60.1%

The single lowest-scoring question (38) clearly highlights the importance of the work outlined in this paper. On this question, RDaSH scored 2.9% 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.

Whilst this need to proactively increase the opportunities and processes by which we engage with patients has been acknowledged in the development of our existing action plan, and specifically Action 3 below, this provides additional clear evidence to demonstrate the importance of this work.

The progress against this action is a core part of our Patient Experience Action 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. This includes developing and monitoring the processes for proactively engaging through Your Opinion Counts, Perfect Ward, Patient Focus Groups, and other sources of insight that are proactively sought, rather than responding to concerns (such as PALS, complaints, incidents).
It also sharply demonstrates the importance of the newly recruited Patient Experience Managers, who will take a lead in driving this important piece of work.

Four of these questions (3,32,33,34) 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

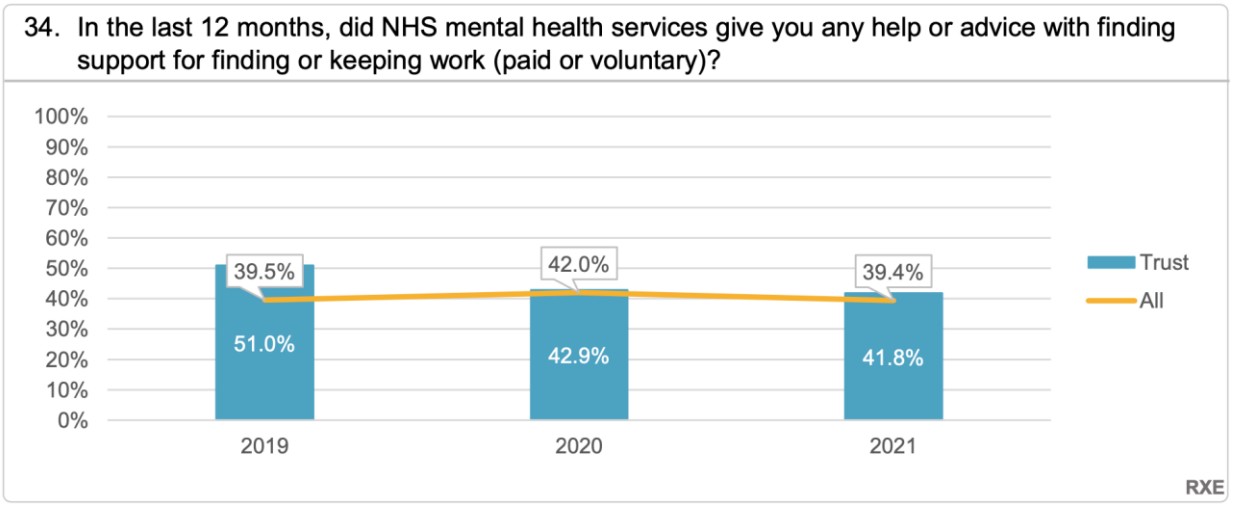
likely to have been a contributing factor nationally.

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. This is backed up by the scores in other questions relating specifically to service access during the pandemic, where again RDaSH outperformed the national average.

Table 20	**Trust Score**	**National average**
Q4: In the last 12 months, were care and services available when you needed them?	69.6%	68.4%
Q5: Were you informed how the care and treatment you were receiving would change due to the coronavirus pandemic?	66.7%	65.0%

RDaSH performed less well in terms of providing help and advice around work (paid or voluntary) and financial advice of benefits.

Again, the score was narrowly above the national average, but did demonstrate a significant decline since 2019, as illustrated in the example below.



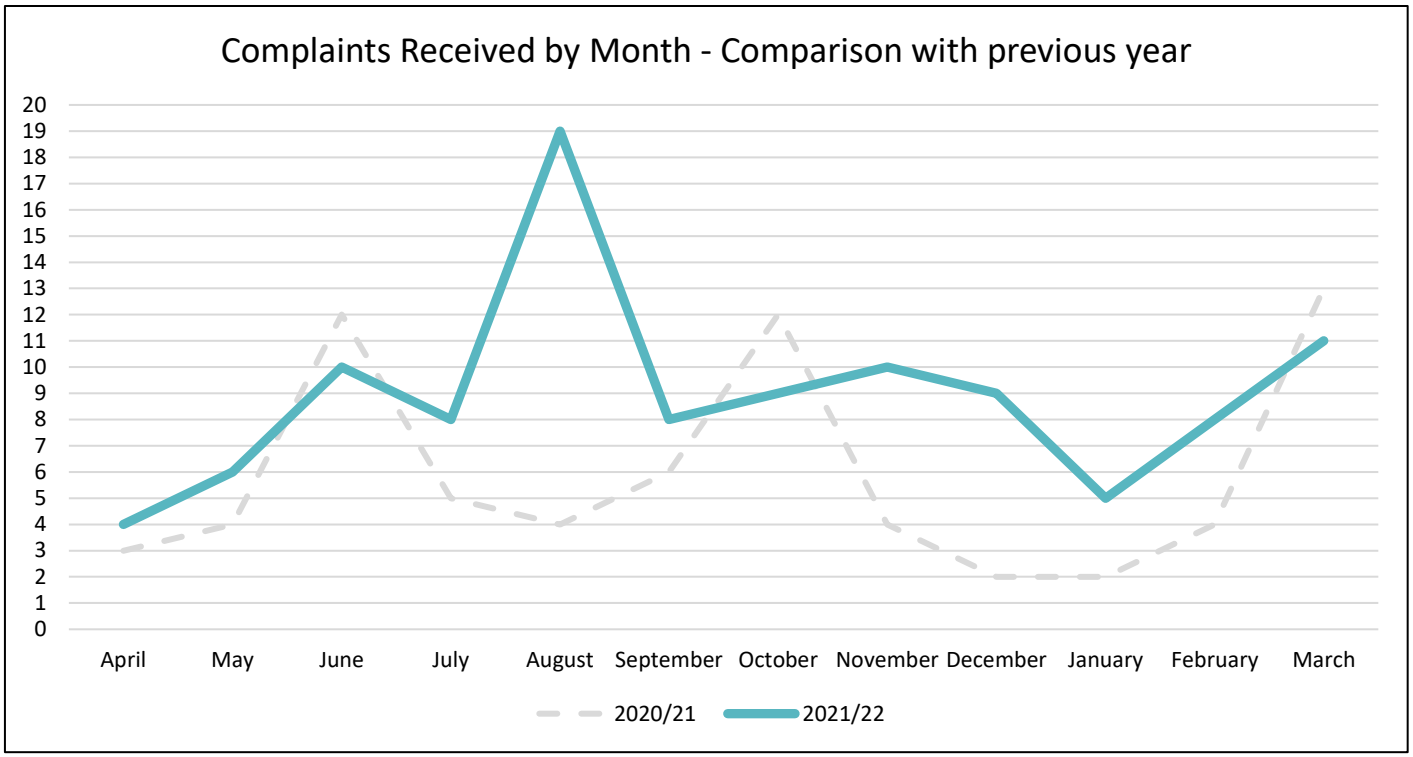
The chart demonstrates that whilst nationally the scores have been static, 9.2% fewer of our patients have reported receiving help of advice around work, and 6.2% fewer received advice about financial support than two years ago.

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)

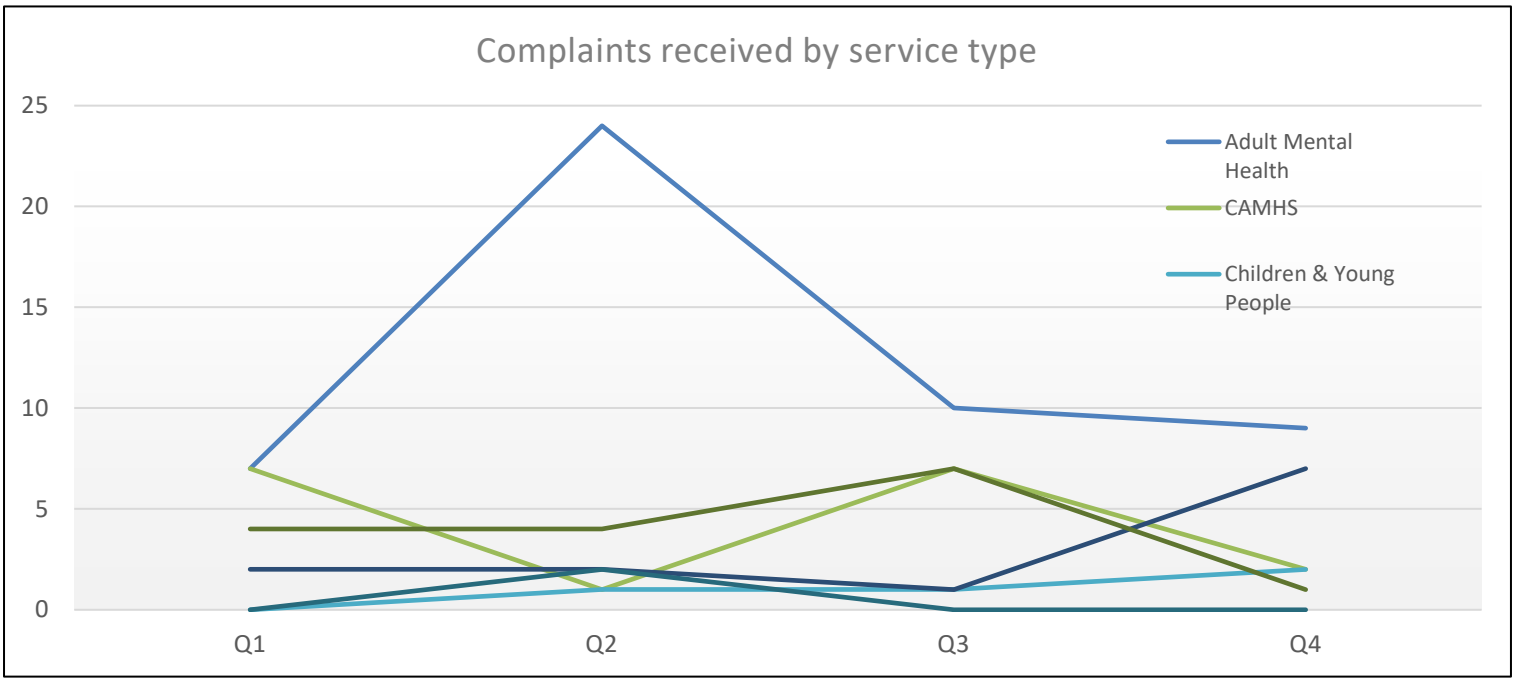
Complaints

In the 2021/22 a total of 92 new complaints were received as illustrated below. The chart shows the number of complaints received by month Trust-wide in 2021/22. The grey dotted line represents the complaints received in the previous year for comparison.

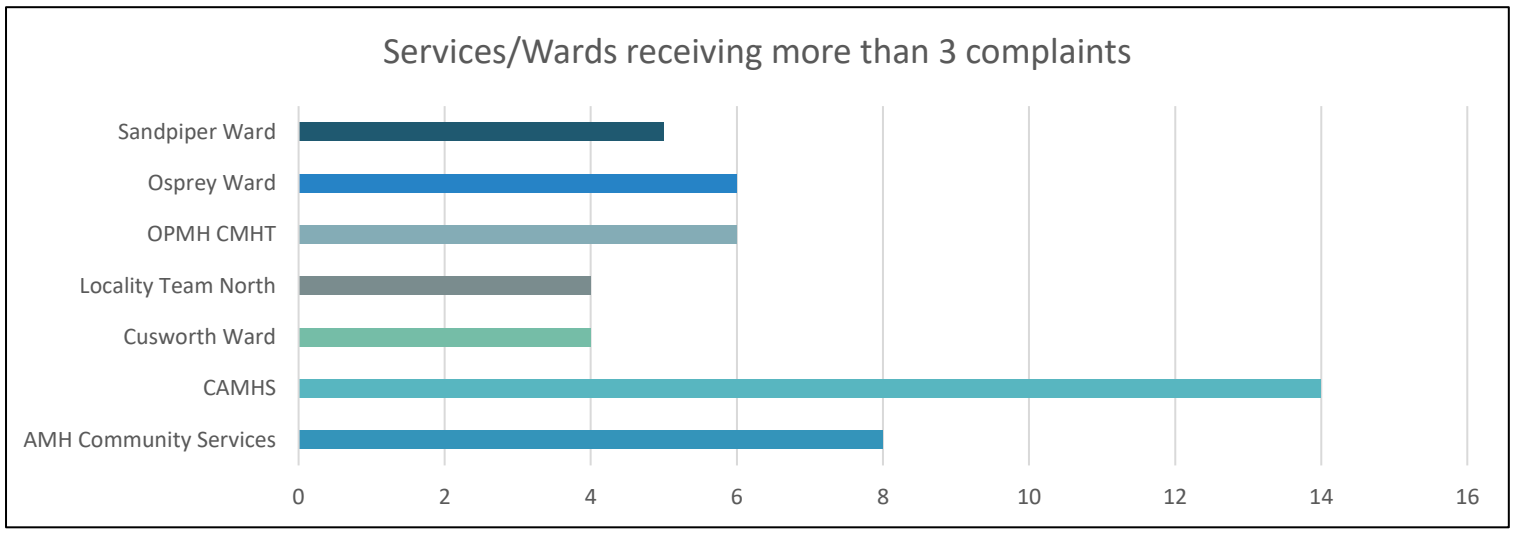


The graph shows wide variation month by month, with several peaks, including a large peak in August this year, with more complaints being received than in any single month in the last 18. This peak coincided with particular staffing and capacity pressures as a result of the pandemic and was largely driven by an increase in complaints relating to Adult Mental Health services. However, this spike was not found in a single area, being spread evenly between Doncaster and Rotherham, and across a variety of service areas and themes. The number of complaints returned to a consistent level subsequently.

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 – and accounted for almost all of the peak in August. Learning Disabilities only received 2 complaints 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:



The majority of these services are inpatient areas, often providing care for patients with higher acuity and additional challenges in terms of complexity. The two inpatient areas with the highest number of complaints, Sandpiper and Osprey Wards, are both within Swallownest Court and the 7 complaints received represent a significant increase, with only one complaint being received in the previous year across both wards.

In response 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. Of the 7 complaints received investigations have been completed in three cases, involving managers, senior nursing teams and the staff involved in each episode. Specific actions taken in response to these complaints include:

- Staff reminded through Safety Huddles regarding the importance of timing activities to respect ward mealtimes

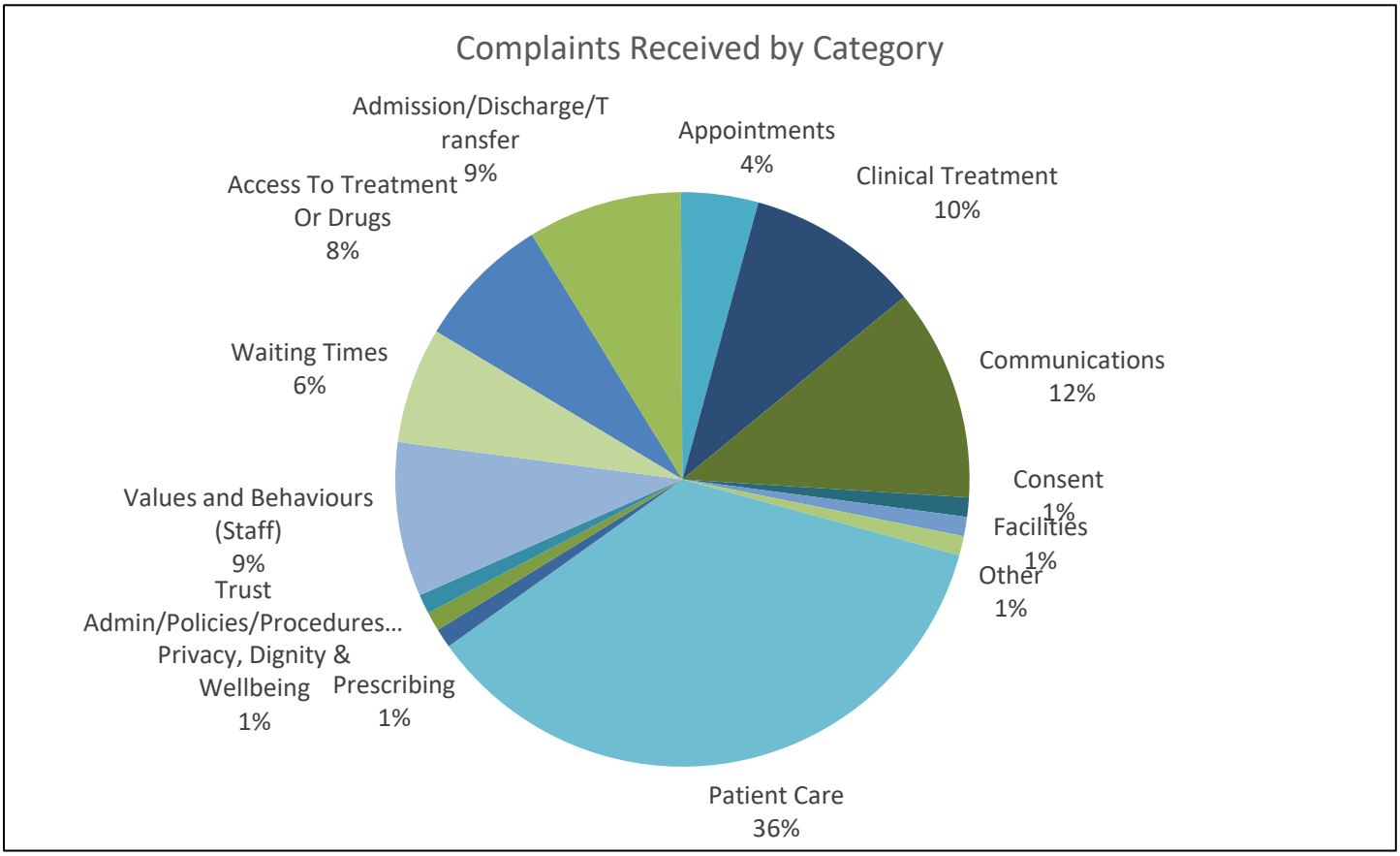
- Awareness raised with staff and patients about the inpatient non-smoking ward policy regarding e-cigarettes, and ensuring this is applied consistently.

The area receiving the most complaints in the period is CAMHS, although it should be noted that this category covers the CAMHS services in all three geographical areas. All of the complaints received in relation to CAMHS have been fully investigated and responses provided, with associated action plans. The most common issue relates to diagnosis, particularly of autism, and the consequent impact on access to services.

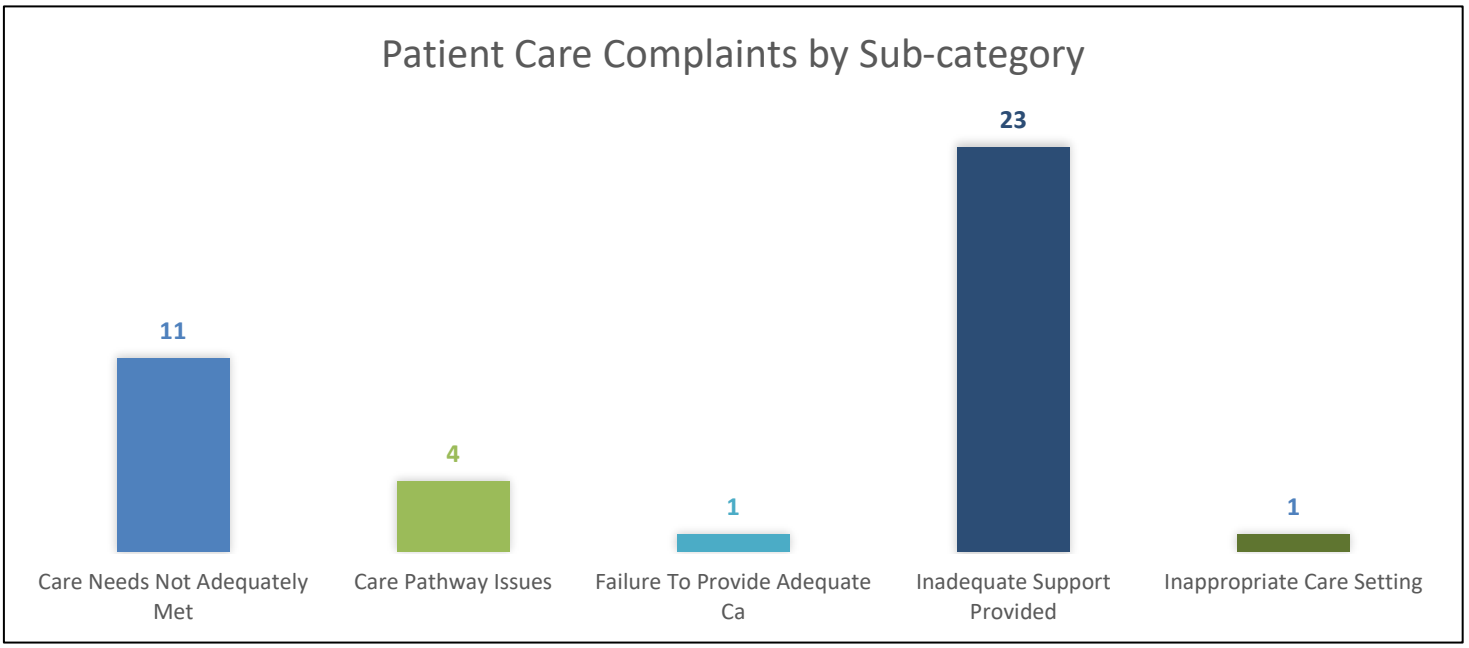
There is a national problem with the neurodevelopment pathway with long delays in awaiting assessments, but it is acknowledged that in particular the CAMHS Service in Rotherham is experiencing an unusually long length of time for neurodevelopmental assessments to be undertaken, higher than the national average.

To address the current waiting times for assessment for neurodevelopmental disorders, the Rotherham Clinical Commissioning Group (RCCG) and Rotherham Metropolitan Borough Council (RMBC) as joint commissioners of the service have supported work across the partnership to develop and embed a local graduated response. As a result, Rotherham CAMHS services have developed a new multi-agency Emotional and Social Wellbeing panel. The panel includes Rotherham representatives from Educational Psychology, Speech and Language Therapy, Learning Support, Children's Disability Family Support & Autism Information and Advice Service along with the CAMHS Neurodevelopmental Assessment service. The function of the panel is to screen referrals into the service for neurodevelopmental assessment ensuring that only appropriate referrals are accepted on to the neurodevelopmental assessment pathway. The progress of this project, including the impact on complaints received will continue to be monitored.

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



In the Patient Care category, when those complaints are broken down further, the most prevalent category is ‘Inadequate Support Provided’, followed by ‘Care Needs not Adequately Met’ which together accounted for 34 individual complaints in the period.



These complaints were largely in relation to inpatient care and split evenly between Rotherham and Doncaster. The issues raised included

- Availability of medical staff/lack of medical intervention
- The impact of a ban on visiting due to COVID-19
- Inappropriate discharge
- Suspicion around motives

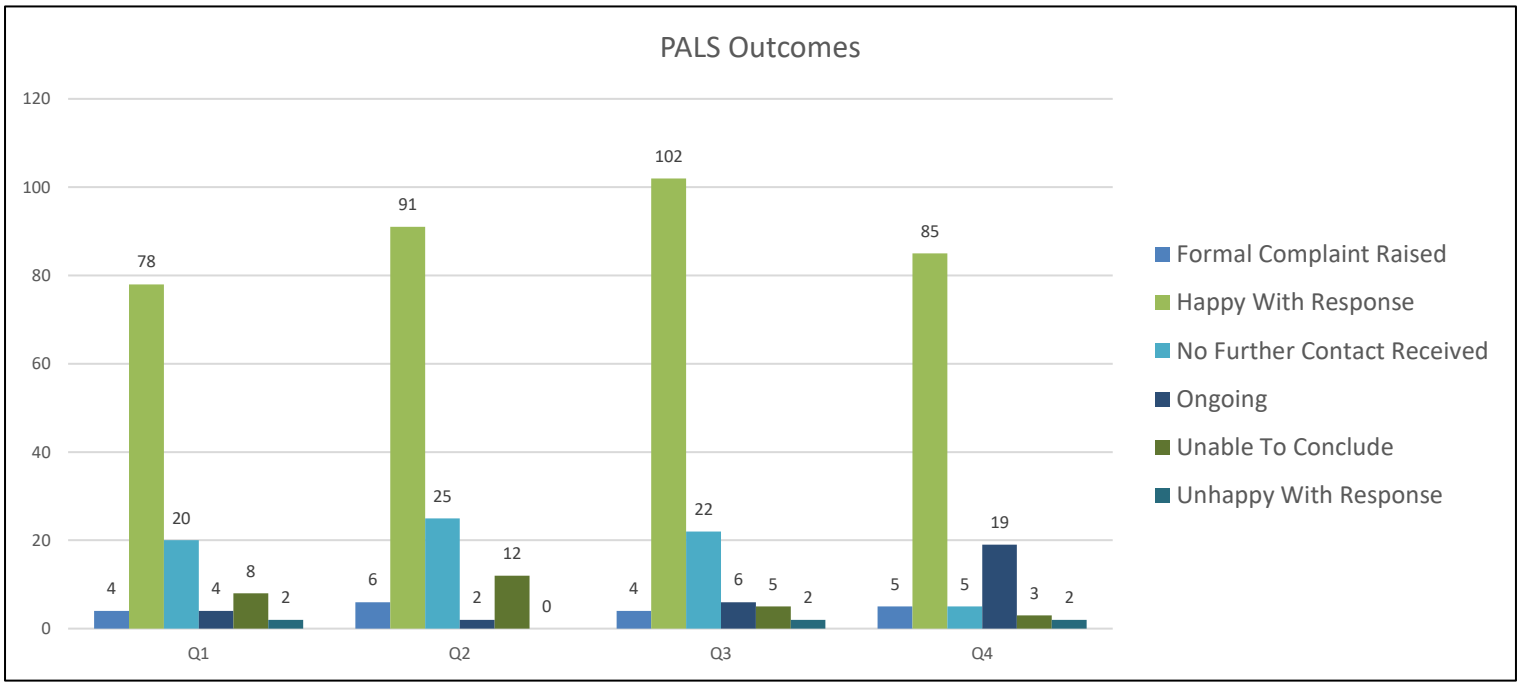
Comprehensive investigations have been completed in relation to the specific issues identified in these cases, and actions taken in response include:

- Additional medical review arranged for patient, to review current health and discuss individual requirements in depth.
- Change in process for allocation of follow-up appointments when appointments are cancelled.

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 346 by almost a third, to 512 – however, more than 20% 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 here. This demonstrates an effective investigation process, with the vast majority of concerns raised via this route resolved satisfactorily, and just 19 (4%) being escalated to formal complaints for the year.



3.3.3 Your Opinion Counts

Table 21 YOCS Received	Care Group						
Quarter	**Children's**	**Corporate**	**Doncaster**	**North Lincs**	**Rotherham**	**Unknown**	**Total**
Q1	59	2	170	72	34	2	339
Q2	55	1	162	58	20	1	297
Q3	91	301	133	61	23	1	610
Q4	93	113	161	49	25	1	442
Grand Total	**298**	**417**	**626**	**240**	**102**	**5**	**1688**

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 has almost doubled from last year's total of 826 to 1688, and all Care Groups but one has benefitted from a considerable increase in returns. The main cause of this increase is down to the successful opening and management of the COVID-19 Vaccination Clinic and the usage of paper forms to gather instant feedback from visitors leaving the building. In October 2021 alone, the Trust picked up 126 responses for this service, which was higher than the rate for all Care Groups in that month combined.

A strategic priority for the Trust is increasing the insight that can be gained from the Your Opinion Counts process, which is also our mechanism for gathering Friends and Family Test information. As part of the Trust's Patient Experience action plan, two new Patient Experience Managers have been recruited, and work already undertaken includes:

- Established a Trust-wide working group specifically to develop and improve our Your Opinion Counts process, and to support a relaunch
- Refreshed and redesigned both electronic and paper versions of the form, including the planned move to a new software platform, allowing a more sophisticated and intuitive design for patients to use at no additional cost to the Trust.

- New questions added around demographics and care episodes to improve the richness and quality of our patient experience data and to ensure we are meeting our responsibilities around patient equality monitoring
- We are working with the Trust's deaf service lead to develop a new BSL version of the form, which will be trialled at a Doncaster community event in Q1. We are also working with LD colleagues to refresh the existing Easy Read format.
- Working with an external patient experience partner to strategically distribute the survey via SMS text messages, bringing us in line with many fellow provider Trusts regionally and nationally who have successfully obtained high levels of quality feedback this way.
- All services are now being requested to include the YOC and/or the FFT question as part of their standard discharge process, including a paper copy and QR code attached to patient discharge letters.
- We have opened dedicated social media accounts to publicise the YOC and other surveys/feedback opportunities, including an upcoming campaign for the relaunch.

Compliments

Table 22: Care Group	**2021/22**	**2020/21**
Children's	16	14
Corporate	1	0
Doncaster	11	11
North Lincs	3	0
Rotherham	0	7
Grand Total	**31**	**32**

The number of compliments received by the Trust has remained consistent overall from last year, and almost all Care Groups saw an increase or stayed the same. Children's Care Group received the highest number of compliments with 16, while Rotherham was the only Care Group to receive 0, a drop from last year's total of 7.

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

Statements were received from:

- Doncaster CCG
- North Lincs CCG
- Rotherham CCG
- Doncaster Health and Adult Social Care Scrutiny Panel
- North Lincs Council Scrutiny Panel
- Rotherham Health Select Commission
- HealthWatch Doncaster
- HealthWatch North Lincs
- HealthWatch Rotherham
- RDASH Council of Governors

NHS Doncaster Clinical Commissioning Group response to the Annual Quality Report 2021/22

Doncaster Clinical Commissioning Group (CCG) is pleased to comment on the Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) annual Quality Report 2020/21 and their quality plans for 2022/2023.

The pandemic has continued to pose many challenges for the Trust as it did for the whole NHS and Social Care system. The Trust maintained a real focus on keeping colleagues, patients, and their loved ones safe and protected as much as possible. While doing this, the quality of service continued to be a priority. The Trust has continued to work collaboratively with all partners to develop services and share resources during these continued challenges.

The Trust CQC Inspection Report was published in February 2020 with a rating of 'requires improvement', following this an action plan was developed to address all issues raised. The continued challenges in relation to the pandemic have impacted on the Trust's ability to deliver on these actions at pace; however; work continued, and we are pleased to state that most actions are now completed.

The trust continues to demonstrate an open and honest culture to safety. The Safety and Quality Strategy is a four-year plan that sets out three key pillars of safety and quality:

- Insight
- Involvement
- Improvement

The CCG are pleased to see the priorities continue to be underpinned by the trusts values and have seen significant achievements during the last year despite the difficulties. Additionally, the review, monitoring and measuring of quality has a robust governance structure which supports the following assurance streams:

- Quality Dashboards
- Board Assurance
- Quality Committee Summary Report to Board
- CQC Inspection Reports and Actions Plans
- Quality Priority Progress Reports
- Internal Audit reports
- Deep Dive investigation and review reports

A number of the above reports and/or minutes from meetings are provided to the CCG Clinical Quality Review Group which provides a further level of transparency and assurance on service provision.

The CCG look forward to working with the trust as they continue with their priorities for improvement in 2022/23 to continue to develop and deliver on the best outcomes for patients in Doncaster.

We would like to take this opportunity to thank the Trust and all their staff for their continued focus, hard work and dedication they continue to show towards the Pandemic response and recovery. We would also like to thank them for their continued drive to re-establishing services in line with the National focus on recovery following the Pandemic. We look forward to working with them collaboratively both in the transformation and redesign of key services and the further delivery of improvements in the quality of care and experience.

Jenny Rayner
Quality & Patient Safety Manager for Children's & Maternity Services
Doncaster CCG

15/6/22

NHS North Lincolnshire Clinical Commissioning Group response to the Annual Quality Report 2021/22

North Lincolnshire Clinical Commissioning Group (NLCCG) welcomes the opportunity to provide comment on the RDaSH Quality Report for 2021/2022. Firstly, the CCG would like to take this opportunity to thank all staff across Rotherham, Doncaster and South Humber NHS Foundation Trust for their hard work and dedication throughout the last year.

Despite another challenging year due to the ongoing Covid-19 pandemic response and recovery, the CCG wish to commend RDaSH on continuing to drive Quality Improvement ensuring it is at the heart of everything they do. RDaSH have refreshed their Strategic Plan for 2021-2023 and the supporting ambitions titled 'Leading the Way with Care'. This welcomed refresh encompasses the learning from Covid-19 and ensures connectivity with their CQC action plan, which has maintained good momentum despite the ongoing pressures.

Additionally, the CCG wishes to highlight the positive feedback it received across the workforce in the annual staff survey. It was pleasing to note that in many areas the Trust is above the national average and very close to being in the top Trust for areas relating to being a compassionate, inclusive, flexible and a motivated organisation. Throughout the last year the Trust have continued to invest in staff health and wellbeing, quality of care and continuing to develop the safety culture, all of which have been reflected within the outcomes of the staff survey.

2021/2022 also saw the introduction of a new pilot scheme relating to the review and implementation of relevant NICE guidance. The pilot enabled a more consistent, timely and effective approach to reviewing and considering compliance with new NICE guidance. For the North Lincolnshire Care Group this has enabled the previous backlog of guidance waiting to be reviewed to be completely eliminated ensuring that national best practice is understood, and timely plans can be established.

Whilst the CCG acknowledges the progress and improvement made by the Trust during 2021/2022 there remain some areas of challenge, including recruitment and retention which has been a particular area of concern across the North Lincolnshire Care Group. The CCG acknowledges the work that the Trust has undertaken so far to improve this position such as international recruitment, new trainee roles and rotational posts, but recognises that this requires ongoing focus especially within the North Lincolnshire inpatient units and the medical staffing team to ensure high quality care can continue to be delivered.

RDaSH has committed to continuing to build on the refreshed strategic plan for 2021-2023, with relevant safety and quality priorities outlined for 2022/2023 which are built around the 3 key areas of Insight, Involvement and Improvement. The CCG (and Place based ICS team post 1st July 2022) will continue to work closely with RDaSH as key system partners and to support the Trust's continued improvement journey.

Helen Davis
Interim Director of Nursing and Quality
Caldicott Guardian
North Lincolnshire CCG

13/6/22

NHS Rotherham Clinical Commissioning Group response to the Annual Quality Report 2021/22

The Commissioner welcomes this opportunity to provide feedback to the Rotherham Doncaster and South Humber NHS Foundation Trust's document 'Quality Report 2021/22.

NHS Rotherham Clinical Commissioning Group would like to thank the Trust and all their staff for their continued focus and dedication in the face of the ongoing challenges on the COVID 19 pandemic.

The CCG is pleased to note the clear progress made to implement the recommendations from the CQC well-led inspection in November 2019. The innovative work on improving patient safety is also of note including the recruitment of patient safety specialists as well as developing patient safety partners (as experts by experience). The impact of the work undertaken to increase the response rates for Your Opinion Counts and the Friends and Family test are starting to be seen and we look forward to seeing how the insights gained through these mechanisms will be used to improve Services.

Through the 2022/23 CQUIN process we look forward to better understanding how well outcomes are measured for Children and Young people, perinatal mental health, IAPT and mental health liaison.

As we transition to an Integrated Care Board, we will continue to work closely with RDASH to deliver effective and sustainable change to improve outcomes for patients during the year ahead.

This statement has been prepared by NHS Rotherham Clinical Commissioning Group (RCCG) in response to the request received from the Rotherham Doncaster and South Humber NHS Foundation Trust.

Dr Anand Barmade
Mental Health GP Lead

Sue Cassin
Chief Nurse

30/5/22

Doncaster Health and Social Care Scrutiny Panel response to the Annual Quality Report 2021/22

The Chair, on behalf of Doncaster's Health and Adult Social Care Scrutiny Panel states that it is obvious in this report the perseverance, tenacity, and commitment staff have shown and continue to show during this turbulent year. The report shows that there is good and consistent learning. Its great to see Schwarz Rounds being used as a learning and reflective tool to enhance patient safety and staff wellbeing. This commitment for patient safety is further shown by the embed measures, such as freedom to speak, that enable and empower staff to speak up about issues that concern them, considering equality, diversity and inclusion. Something that is incredibly important to patient care, safety and staff resilience.

We look forward to the Trust's deaf service development on a new BSL version of a form, which will be trialled at a Doncaster community event. And it's fantastic to see that Doncaster has received 11 compliments for its services.

It is noted that an area to build upon that is not really discussed in this report and would be an asset to help improving services and safety, is carer involvement. There has been an increase in reports of carers not being involved or communicated with about a person's care. This would make a good area to add onto next year's report and to be able to utilize carers better as an equal part of a person's care team.

Christine Rothwell
Doncaster Metropolitan Borough Council
Senior Governance Officer

7/6/22

North Lincolnshire Council – Health Scrutiny Panel response to the Annual Quality Report 2021/22

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 2021/22. RDaSH are a key partner and provider of local services, and members have built a valuable working relationship with Trust personnel over recent years.

Unfortunately, it was not possible to arrange a meeting with RDaSH to discuss the draft Quality Account prior to submission. However, we received the document and will be meeting with Trust representatives in the coming weeks, and will be feeding back to the Trust leadership. As such, we do not intend to comment in any depth on the draft document, other than to note the encouraging internal audit reports as outlined in Table 2, and to state that we fully support the identified priorities for the coming year.

Cllr T Mitchell,
On behalf of North Lincolnshire Council's Health Scrutiny Panel

13/6/22

Rotherham Health Select Commission response to the Annual Quality Report 2021/22

Members appreciated being invited to review the RDaSH Quality Account for 2021/22.

Members found the action plans promising, especially in regard to improvement and engagement, where significant quality issues persist. Members will be keen to see the Trust follow through on these plans within target timescales and, most importantly, demonstrate how each action raises quality of care for Rotherham residents.

Members note that the February 2020 CQC inspection found quality of services had declined before the pandemic even began. Therefore, initial steps toward improvement had to be undertaken amid pandemic conditions. We know that the pandemic has exacerbated health inequalities, which means that the need for safe, effective and well-led services, especially mental health services for children, young people, and working age adults, is more urgent than ever.

Engagement rates reflected in the Quality Account are worryingly low overall, and Rotherham remains underrepresented in feedback, reinforcing Members' desire for assurances that Rotherham residents have equal access to RDaSH services at the point of need. The account conspicuously fails to include the results of the Trust's Friends and Family Test (FFT) which the document describes as a crucial performance indicator. Members would have liked to see a full, transparent breakdown and analysis of the results and how the insight from the FFT is being turned into action to drive improvement.

In view of this, Members expect to see more proactive leadership setting a positive example in future by prioritising engagement with Rotherham residents through participation in public scrutiny and other accessible channels whereby the voices of patients and stakeholders and their elected representatives can edify needful progress.

Members affirm the intention of the Trust to improve services and thank the staff for their efforts throughout the pandemic on behalf of Rotherham residents.

Cllr Taiba Yasseen
Chair
Health Select Commission

10/6/22

Healthwatch Doncaster response to the Annual Quality Report 2021/22

The enormous challenges posed by the Covid-19 pandemic and the knock-on effects on the provision of healthcare persisted throughout the year 2021-2022, but RDaSH has continued to engage with local communities in a number of innovative ways to try and keep conversations going with the citizens of the Borough.

As the eyes, ears and voice of the people of Doncaster, we will always seek to increase the influence of our citizens in the commissioning and delivery of services and recognise that the Trust is listening to what the population of Doncaster is saying and acting upon what they hear.

In the future, we hope that an increased emphasis on Place will mean that services are more local and tailored to the needs of the community. The provision of better mental health services is a key area for the Borough to focus upon and we are keen to be part of the conversation.

Fran Joel
Chief Operating Officer
HealthWatch Doncaster

8/6/22

Healthwatch North Lincolnshire response to the Annual Quality Report 2021/22

Healthwatch North Lincolnshire welcomes the opportunity to make a statement on the Quality Report 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 about the quality of service they provide.

The report identified the achievements made against the actions set out in the Safety and Quality plan and it was encouraging to read about the positive progress made to date, especially around patient feedback with improvements to the Family and Friends Test. Similarly, it has been interesting to read about the progress against 2021/22 priorities for improvement, which highlighted the opportunities that, patients, carers and families have to contribute towards improvements in patient safety, such as the introduction of Patient Safety Champions. However, more information about the methods that patients and families can use to report safety incidents would have been useful along with how these methods are promoted within the community.

Achievements made towards dealing with complaints is welcomed including: plans to undertake staff training on responding to complaints and the planned introduction of a handbook about managing complaints. Other positives noted within the report included: the planned work around suicide prevention and the Trusts continued participation in clinical audits and understanding what can be learned from these. The 'Freedom to Speak Up' initiative for staff is also positive and the quality accounts highlight methods that staff have to raise concerns, such as directly with the Freedom to Speak UP Team (FTSU) or anonymously using the staff intranet.

Developments specifically targeted towards North Lincolnshire are noted including improved relationships with, third sector, Drug and Alcohol services. The extra investment received by the Trust for its mental health services is also positive, including receiving an extra £317,000 for the North Lincolnshire IAPT service and £178,000 towards the Community Mental Health Transformation Programme.

However, despite this much of the information provided within the quality accounts, including reporting against core indicators and sharing information from the Community Mental Health 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 the Trust's work at a local level.

Jennifer Allen
Delivery Manager
Healthwatch North Lincolnshire

6/6/22

Healthwatch Rotherham response to the Annual Quality Report 2021/22

Healthwatch Rotherham again welcomed the opportunity to provide comments and a response to the RDaSH Quality Account for 2021/2022. We recognise the report plays a significant role in ensuring NHS Trusts are accountable to the patients and members of the public about the quality of service they provide.

Healthwatch Rotherham acknowledges that there have been continued challenges because of the Covid 19 Pandemic and congratulates RDaSH for their continued commitment to the Community Mental Health Survey, Complaints and Patient Advice Liaison Service and Your Opinion Counts analysis (YOC). This commitment helps to gain insight into service provision, what works well and what requires improvement.

There is a clear direction to improve the use of YOC within the Quality Account, alongside a strong sense to develop and improve the process. It is good to see the Trust is working with colleagues to ensure individuals are not excluded by working to offer a new British Sign Language (BSL) version of YOC and refreshing the easy read format for people with learning difficulties.

It is also positive to see the variety of ways in which people can access the YOC by offering SMS text messaging, dedicated social media accounts and promotion through all discharge papers. Some examples include a paper copy so as not to digitally exclude anyone and a QR code for ease of access for those with electronic devices. As an observation, it would be good to see more face to face public engagement now we are returning to some normality after the Covid 19 pandemic.

Healthwatch Rotherham welcomes any future collaboration opportunities which may arise to involve the people of Rotherham and their views with ongoing engagement work RDaSH completes in the future to improve quality across service provision.

Natalie Palmer
Service Manager
Healthwatch Rotherham

10/06/22

Rotherham Doncaster and South Humber NHS Foundation Trust - Council of Governors Statement for 2021/22

The Council of Governors is pleased to have the opportunity to comment on the Quality Report for 2021/22.

For the second year in a row, and whilst the Trust continued to deal with the Covid-19 pandemic, there has been the need to significantly adjust the engagement activities of the Council of Governors throughout the year. This has again resulted in a reduction in the opportunities for the Council of Governors to be closely involved with initiatives to promote and assure quality services within the Trust. However, listed below are brief details of some of the ways that Governors have been included:

- The Council of Governors received comprehensive 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 received written and verbal updates periodically throughout the year highlighting key updates and information about the Trust and in particular how it has been dealing with the impact of the pandemic – including the impact on services and staff. These have been through the formal Council of Governor meetings and through other ad-hoc communication.
- A number of Governors have attended (virtually) 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 service users, carers and stakeholders in how the Trust delivers its services but looks forward to having an even greater opportunity once restrictions are fully lifted.

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

- Non-Executive Director interview and (re)appointment processes – predominantly undertaken by the Governors on the Nominations Committee but resulting in recommendations being made to the full Council of Governors. Governors also participated in the recruitment to the Executive posts of Director of Nursing and AHPs and the Medical Director.
- The Governors have, during the year had access to a programme of training provided by NHS Providers (Governwell) and a number of national updates and conferences that have all contributed to a better understanding of the role and responsibilities.

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 will work 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. Since the start of the new financial year (2022/23) the joint service visits, that Governors undertake with members of the Board of Directors, have

recommenced and Governors will be represented in Q1 as the Trust embarks on the production of a new Clinical Strategy and the Trust's long term strategy.

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
16 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
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 2021/22 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 2021 to March 2022
    - papers relating to quality reported to the board over the period April 2021 to March 2022
    - feedback from commissioners:
        - Doncaster Clinical Commissioning Group 15 June 2022
        - North Lincolnshire Clinical Commissioning Group 13 June 2022
        - Rotherham Clinical Commissioning Group 30 May 2022
    - feedback from Council of Governors 16 June 2022
    - feedback from Doncaster Healthwatch organisation 8 June 2022
    - feedback from North Lincolnshire Healthwatch organisation 6 June 2022
    - feedback from Rotherham Healthwatch organisation 10 June 2022
    - feedback from Overview and Scrutiny Committee:
        - Doncaster Health and Adult Social Care Scrutiny Panel 7 June 2022
        - Rotherham Local Authority Health Select Commission 10 June 2022
    - the trust's complaints report 2020/21 published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 and the quarterly reports for 2021/22;
    - the latest national community mental health patient survey 2021
    - the latest national staff survey 2021
    - The CQC Inspection report dated 21 February 2020
    - the Head of Internal Audit's annual opinion of the trust's control environment dated 8 June 2022
- 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.

Kathryn Singh, Chief Executive

Alan Lockwood, Chairman

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
CCG:	Clinical Commissioning Group
CQC:	Care Quality Commission
CQUIN:	Commissioning for Quality and Innovation
Dashboard:	Summary overview of key areas of performance
IAPT:	Improving Access to Psychological Therapies
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
PLACE:	Patient-led assessments of the care environment, which is the new system for assessing the quality of the patient environment
PMVA:	Prevention and management of violence and aggression
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.