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About our Quality Report

Required by the Health Act 2009, our published Quality Report (including our Quality Account) provides the public with a report each year of our commitment and accountability regarding the quality of healthcare services we deliver. It is also an opportunity for the Trust to offer its approach to quality up for scrutiny, debate and reflection by the public.

The Quality Report incorporates all the requirements mandated by NHS Improvement and/or by The NHS (Quality Accounts) Amendment Regulations 2017, however other parts are determined locally and shaped through the feedback we receive.

Each year our Quality Report reviews the preceding year’s key quality improvement achievements and challenges, and sets out our quality priorities for the forthcoming year; ensuring that we maintain a balanced focus on the three key domains of quality:

- Patient Safety
- Clinical Effectiveness
- Patient Experience.

The Quality Report is in three main parts:

Part 1

- Provides a statement summarising the Trust’s view of the quality of health services provided or subcontracted during 2018/19.

Part 2

- Provides a review of performance against the priorities for improvement as identified in our 2018/19 Quality Report
- Sets out our quality priorities for 2019/20 and how progress to achieve these priorities will be monitored, measured and reported
- Includes statements of assurance from the Trust Board
- Provides a report on performance against a set of core indicators using data made available by NHS Digital.

Part 3

- This section provides an overview of the quality of care delivered by the Trust against a number of local indicators as well as performance against relevant indicators set out in Monitor’s Risk Assessment Framework (2015)/NHS Improvement Single Oversight Framework (updated November 2017).
1. Statement on quality from the Chief Executive

Welcome to the 2018/19 edition of the Quality Report for Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) (the Trust).

RDaSH provides a range of health and social care services across the, Rotherham, Doncaster and North Lincolnshire localities, through a Care Group model:

- Rotherham Care Group - provides Adult Mental Health Services, Older People’s Mental Health Services and Community Learning Disabilities Services.
- Doncaster Care Group – provides Adult Mental Health Services, Older People’s Mental Health Services, Drug and Alcohol Services, Community Learning Disabilities Services, Forensic Services and Community Physical Health Services.
- North Lincolnshire Care Group – provides Adult Mental Health Services, Older People’s Mental Health Services and Community Learning Disabilities Services.
- Children’s Care Group – provides a range of Children, Young People and Families Services including Children’s Mental Health across the three localities, Rotherham, Doncaster and North Lincolnshire.

The report summarises our progress and improvements for 2018/19 along with the learning across the Trust and our plans as we move in to 2019/20 as we continually strive to deliver our strategic vision of ‘Leading the Way with Care’.

2018/19 has been a year of significant progress for the organisation in the delivery of our quality priorities, and our achievement of these priorities is included in this report. In addition, 2018/19 has seen the development of ‘Our Five Year Strategy 2019-2024 – RDaSH leading the way with care’, which was launched on the 1 April 2019.

The Strategy incorporates ‘Our Quality Commitment’:

‘We recognise the importance of a single approach to quality and quality improvement. In response to this we give our commitment to deliver an approach that will span all areas of the organisation, embedding systemic discipline and consistency within every department and service. This method ensures we allow for consistent, reliable, repeatable outcomes to be achieved in the easiest possible way.

To successfully embed our quality commitment we recognise the need for strong leadership to drive a culture of quality improvement within a defined quality system, engaging people through our shared vision and allowing our people the time to make changes and to innovate.

Our approach will ensure continuous improvement is at the core of our strategy to recognise the ever changing environment within which we operate and will place the quality of care and patient outcomes as the central success factor in defining qualitative success. Our Trust quality approach means that we will co-produce and deliver safe and effective high quality care.’

During 2018/19 a review of how we deliver quality improvement and provide assurance on our quality improvement has led to the transition of quality improvement into the Workforce and Organisational Development directorate and establishment of Improvement and Cultural Development Teams. The Nursing and Quality Directorate has retained the assurance element of this work. This revised structure will aim to drive and embed quality, triangulating assurance and improvement (through development of quality objectives and underpinning measures) as a key priority across the Trust.

Our other key achievements for quality during 2018/19 include:

- In February 2018, Care Quality Commission (CQC) conducted a ‘Well-Led’ inspection of our core services. The inspection report was published in June 2018 and the Trust achieved (and maintained) an overall rating of GOOD.
- 2018 marked the 70th year since the launch of the NHS in 1948. To celebrate this landmark year the Trust was involved in a number of 1940s themed events along with a summer fair and ward parties. The Trust also had staff invited to Westminster Abbey and York Minster as part of the national celebrations.
The Trust’s continuous service improvement programme has enabled some significant achievements this year in the drive to improve the care we are able to deliver to our patients. We have continued to develop and expand our model for co-ordinated services within which sits various priority areas including:

- The expansion of our single point of access and making progress towards implementing an integrated estate which will be initiated in 2019/20.
- Commenced the rollout of agile working across all clinical services, completing the whole of the Rotherham Care Group in 2018/19 and planning to support expansion across Doncaster and North Lincolnshire in 2019/20.
- Commenced clinical testing of voice recognition software to explore new technologies to release time to care and improve our responsiveness and we have continued to develop our electronic patient record system, achieving significant data sharing capability with our primary care partners in 2018/19 to support the delivery of safe and joined up care.

During 2018 a number of staff were trained to be inpatient nutrition champions.

The launch of a co-produced Carers’ Charter on 6 December 2018 at the Trust wide Carer Champion Network.

In 2018/19, the Trust Going the Extra Mile Awards (GEM) awards were introduced to say thank you to outstanding individuals who have been seen to go the extra mile in the delivery of their job and to praise the work and commitment shown by staff members. The first awards were celebrated in April of that year. To date we have held 11 awards ceremonies awarding over 212 members of staff with a GEM certificate and a special badge to show they are a Trust GEM.

In early 2019 the Trust joined forces with Don Valley MP Caroline Flint to host an information event to help children living with parents who have problems with their use of alcohol.

The Doncaster Child and Adolescent Mental Health Service became one of nine national pilot sites for the trial of a new approach to assessing the mental health needs of children and young people.

On 16 January 2019 the first Black, Asian Minority Ethnic (BAME) network took place. This network provides a platform for people to get together to talk about their experiences and share best practice ideas with an overall aim of promoting personal development and diversity.

On 7 February 2019 Professor Chris Whitty officially launched the Trust’s new community clinical research facility which gives residents across the region more opportunities to take part in research to improve treatment and care for people with mental health conditions.

On 11 March 2019 the Rotherham Care Group launched a perinatal drop in ‘meet and greet’ session.

In 2014 the Aspire addiction services launched its peer mentor programme and 2018 saw the Trust reach a total of 120 trained peer mentors, 17 of whom have gone onto full time employment since the start of the programme.

The Clinical Audit Team completed and reported a total of 41 audits of the 56 projects/topics scheduled on the 2018/19 Clinical Audit programme. Of these, 20 audits were rated with an overall score of ‘Good’ and 14 audits scored an overall outcome of ‘Requires Improvement’ and have action plans in place to address this. No clinical audits were rated as ‘Inadequate. At the time of this report, the Trust is still awaiting the reports from seven National Audits we have participated in; and 15 clinical audits have been carried forward to the 2019/20 clinical audit forward programme.

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 2018/19 Quality Report is accurate.

Our annual report 2018/19 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
24 May 2019
Part 2

The Trust’s ‘Our Five Year Strategy – RDaSH leading the way with care’

During 2018/19, the Trust has developed a five year strategy (2019-2024) ‘RDaSH leading the way with care’, which was ratified in March 2019 by the Board of Directors (Trust Board) and launched across the Trust from 1 April 2019. The vision of the strategy is to ‘provide high quality care, drive innovation and deliver the best possible outcomes for our patients’. In order to achieve this, the Five Year Strategy is underpinned by a Trust wide internal strategic plan (and identified strategic objectives) and corporate strategies including one for quality.

The strategy can be accessed via the Trust website at http://nww.intranet.rdash.nhs.uk/rdash-five-year-strategy-launch/

Our Six Ambitions

To deliver our vision of ‘leading the way with care’, we have set out six strategic ambitions that are underpinned by our values and quality commitment. We believe that by achieving our ambitions, we will create a platform upon which to provide high quality care, deliver excellence, drive innovation and deliver the best outcomes for our patients.

Our Values

Identified in the Five Year Strategy are our values which ‘define who we are, what we believe and how we will work to deliver high quality care to ensure the best outcomes for our patients.’

Our values are:
Our Internal Strategic Plan

This plan provides direction and stability to support the Trust's progress against the 6 strategic ambitions which are targeted at improving services for our patients, our people, our members and our communities.

Progress against the plan will be governed by the Trust Board of Directors and deliverables reported in the Annual Quality Report for 2019/20.

2.1 Priorities for Improvement 2019/20

2019/20 (Year 1) Quality objectives

During 2018/19, work has been undertaken within the Trust on a number of areas relating to quality which are detailed in Part 3 of this report.

During the latter part of 2018/19, the Trust has developed ‘quality objectives’, for improvement for Year 1 (2019/20). The quality objectives are aligned and contribute to the Trust’s overall six strategic ambitions as part of the Five Year Strategy leading the way with care”.

Table 1 below identifies the 2019/20 (Year 1) quality objectives and what the Trust aims to achieve during 2019/20.

<table>
<thead>
<tr>
<th>Quality Objective 2019/20</th>
<th>What do we want to achieve during 2019/20?</th>
<th>How are we going to achieve it?</th>
</tr>
</thead>
</table>
| RDaSH will develop as a learning organisation focusing on safety, effectiveness and innovation | • Implement Human Factors principles and methodology.  
• Implement Safety Huddles.  
• Improve performance in the timely investigation of complaints and serious incidents. | • Undertake safety huddles.  
• Implementation of the NHS Productive Series “Know how you are doing.”  
• Facilitate Quality Practice Development Learning Events.  
• Implement a system to ensure timely dissemination and action in response to key learning from complaints and incidents.  
• Roll out ‘Human Factors Training’ by a Train the Trainer programme. |
| RDaSH will keep patients safe through developing approaches to minimising and eliminating the risks linked to patient harm. | • Improve the function of electronic systems currently used in patient safety or quality governance processes.  
• Produce a Patient Safety Strategy.  
• Produce a harm reduction plan.  
• Produce a strategy for reducing the risks associated with patient suicide. | • Development of an integrated strategy to minimise/eliminate the risks associated with patient harm.  
• Implement a comprehensive delivery action plan to minimise eliminate the risks associated with patient harm. |
| RDaSH will improve patient care and treatment by delivering person-centered care and treatment that integrates physical and mental health | • Explore technology to improve patient care and management including body warn cameras, quality and safety assessment applications and community case management solutions. | • Develop an NHS Productive Series “Patient status at a glance” system.  
• Develop a strategy for ensuring that care records are consistent across RDaSH and are effective in supporting person-centered and outcomes focused care and treatment. |
Measuring and Monitoring of 2019/20 (Year 1) Quality Objectives Progress

It is acknowledged that the two year quality priorities for 2017-2019 did not have specific and measurable objectives and were not SMART. This has been addressed following the Internal Audit (360 Assurance) Final Report (Quality Governance) and work has been undertaken in the 2018/19 with the engagement of Trust staff to set SMART quality objectives for 2019/20.

Progress of achievement against these SMART objectives will be measured and monitored (on a minimum quarterly basis), via the Trust’s governance structures for quality utilising the following methods:

- Engagement with Care Group leadership teams and “frontline staff” and patients to review progress/achievement.
- Inclusion in the Corporate Delivery Plans for Quality Compliance and Assurance, Patient Safety, Clinical Effectiveness and Patient and Public Engagement and Experience (PPEE).
- Inclusion in the Care Groups’ quality objectives delivery plans.
- In the Care Group assurance meetings (for quality).
- Inclusion as established “expected outcomes” and improvement metrics/indicators for reporting within 2019/20 quality objective delivery plans (at Directorate and Care Group level).
- Through the Trust’s Integrated Performance Dashboards.

The objectives are aligned and contribute to achievement of the Trust’s overall strategic objectives and six ambitions as outlined in our Five Year Strategy.

Reporting 2019/20 (Year 1) Quality Objectives Progress

Progress on achievement/success of the quality objectives will be reported via:

- Reporting to Quality Committee via assurance and exception reporting from Sub Committees/groups e.g. monthly Care Group assurance meetings (quality).
- Alignment to Trust reporting against their overall strategic objectives and six ambitions within the Trust’s Five Year Strategy and underpinning Internal Strategy Plan.
- Inclusion in the Trust’s Annual Quality Report and Forward Strategy.
- Inclusion in the Trust’s schedule of reporting (forward plan) for regular reporting (minimum on a quarterly basis) at Quality Committee.
Progress and performance of the priorities for improvement 2018/19

The Trust identified two year quality priorities for 2017-2019 (of which 2018/19 was year two) which were aligned to achievement of the Trust's overall strategic goals for quality. The priorities for 2018/19 were as follows:

- To provide safe effective care.
- To ensure services actively listen and respond to our communities, patients, service users and our people.
- To holistically integrate physical and mental healthcare.
- To create a single, Trust-wide quality information system.
- To develop and implement a Quality Improvement (QI) model and methodology.

The Trust used these to provide an overall measure of improvement against the three quality domains of:

- Patient safety.
- Clinical effectiveness.
- Patient experience.

and our additional Trust quality domain of 'Our people/staff'.

During 2018/19, progress against the quality priorities was reviewed and monitored by the Trust's Quality Committee in January 2019 (up to Q3) and April 2019 (end of year) with performance reported against both national and local quality metrics/indicators.

The Trust's end of year (31 March 19) position in relation to achievement against the 2018/19 priorities, is shown in Table 2 below.
<table>
<thead>
<tr>
<th>Trust Quality Priority</th>
<th>Priority Area</th>
<th>Why is this important?</th>
<th>What do we want to achieve during 2018/19?</th>
<th>Progress/Performance during 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>To provide safe effective care.</td>
<td>• A trust wide integrated organisational learning methodology.</td>
<td>To continuously drive quality and patient safety improvements in standards of care.</td>
<td>The Trust aims to be in a position where there is evidence of consistent patient/carer engagement in the management of risk.</td>
<td>Criterion relating to patient and/or carer engagement/ involvement and experience are assessed and reported against in many key Trust wide risk audits, including:</td>
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<td>• Mandatory/Statutory training compliance.</td>
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<td>• Supportive Observations.</td>
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<td>• Risk assessment – clinical.</td>
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<td>• The ‘Care Programme Approach’ (CPA).</td>
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<td>• Mental Capacity Act (MCA) compliance.</td>
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<td>• Clinical Risk.</td>
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<td>• Care Records.</td>
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<td>• Seclusion.</td>
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<td>For example, the ‘Supportive Observations Audit’ criterion are:</td>
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<td>• The patient should be given a verbal and written explanation of the increase in observation levels.</td>
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<td>• The patient is given a full explanation as to why the search is being carried out.</td>
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<td>• It should be recorded whether the patient gives consent for their relatives to be informed of the increase in observations.</td>
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<td>• It should be recorded whether the patient has been given an information leaflet.</td>
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<td>• The patient should be offered a copy of their observation care plan.</td>
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<td>Patients were also requested to complete a survey which asked whether they had the reasons for observations explained, whether they have been given sufficient information, and whether any questions on the restrictions imposed were answered adequately. The outcomes of which are reported in the final audit report.</td>
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<td>Seclusion audit criterion:</td>
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<td>• Family/carers are notified of the patient being placed in seclusion.</td>
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<td>• A review of the themes and trends of the risk audits is taking place and will inform and tailor bespoke and targeted audits into 2019/20, as part of the annual audit programme.</td>
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<td>Patient and carer engagement has taken place in staff training and practice development days.</td>
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## Trust Quality Priority

**To provide safe effective care.**

<table>
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<tr>
<th>Priority Area</th>
<th>Why is this important?</th>
<th>What do we want to achieve during 2018/19?</th>
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<td></td>
<td></td>
<td>By 2018/19 year-end, each ward and clinical service will achieve the Trust target of 90% for mandatory and statutory training.</td>
<td>At year end the overall Trust compliance figure is 91.26%. Wards and clinical services receive their own figures and those that are below the 90% Trust target had plans in place to achieve the required level of compliance by year end.</td>
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</table>
|               |                        | To have in place a robust approach to risk assessment and management of clinical risk across the Trust clinical services. | A literature review of clinical risk assessments has been undertaken. The results of which will be used to inform a review of the current clinical risk assessment tool which is used within the Trust, led by the Interim Head of Patient Safety. To support this review changes have been made to some processes and internal reporting systems to ensure that real time data is available to underpin decisions around clinical risk. Significant staff training on aspects of clinical risk assessment has taken place during Q4 of 2018/19 via a ‘train the trainer’ programme. This training will be rolled in 2019/20, with the trainers cascading and dissemination across relevant service across the Trust. The training includes:  
  - The Trust has been utilising the ‘Applied Suicide Intervention Skills Training’ delivered by STORM training. Additional staff across the Trust has completed the training in March 2019.  
  - A series of consultation events have taken place with staff and resulted in the development of a bespoke module for the reporting of mortality on Ulysses incident reporting system. This will ‘go live’ in Q1 of 2019/20.  
  - A package of training around the impact of Human Factors on clinical decision making and risk was completed by a selection of team and senior managers in February 2019. Further staff training in the use of the structured review methodology is planned for May 2019 which will be delivered by the Royal College of Psychiatrists. |
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<tr>
<th>Trust Quality Priority</th>
<th>To provide safe effective care.</th>
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**Trust Quality Priority** | To ensure services actively listen and respond to our communities, patients, service users and our people |
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<td>Priority Area</td>
<td>Why is this important?</td>
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<td>• To implement the Trust’s 3 year strategy on patient and public engagement and experience. • Act on feedback from patients, family and carers and the public to improve patients experience when accessing the services the Trust provides.</td>
<td>To achieve the aims and objectives of: • Triangle of Care. • The Trust ‘Patient and Public Engagement and Experience strategy.’ • Sustainability and Transformation Plans for each locality. • CQC requirements on patient experience.</td>
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<tr>
<td>Trust Quality Priority</td>
<td>To ensure services actively listen and respond to our communities, patients, service users and our people</td>
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<td>Trust Quality Priority</td>
<td>To holistically integrate physical and mental health care</td>
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<td></td>
<td>• Achieve parity of esteem in care delivery through 'valuing mental health equally with physical health'.</td>
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<td>• The Trust will be Smoke Free.</td>
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<td>• As part of the ‘Future in Mind’ agenda for children and young peoples’ well-being; work with School Nursing and Community Nursing to ensure that the emotional well-being of these patients is assessed.</td>
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<td>• Clinical pathway development.</td>
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<td>Trust Quality Priority</td>
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<td>Progress/Performance during 2018/19</td>
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<td>During 2018/19 it was identified that the ‘Physical Health Policy’ required a review to enable a clinical audit to be undertaken against the revised policy. The policy has been reviewed in consultation with clinical staff. It is currently out for comments via the Physical Health Strategic Group and on completion will be presented to the Clinical Policies Review and Approvals Group (CPRAG) in June 2019 for approval. A clinical audit of compliance with the revised policy (following approval) is scheduled to commence in Q2 of 2019/20, as part of the annual audit programme. On completion of the audit, assurance will be provided by the audit report findings; overall audit score and robust audit follow up arrangements.</td>
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<td>That 95% of all patients/service users have a physical health and well-being assessment recorded within seven days of admission.</td>
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<td>That 95% of all patients/service users will have an emotional well-being assessment recorded at initial contact assessment with School Nursing and Community Nursing services.</td>
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<td>During 2018/19 the data warehouse was launched which allows formal data reporting of performance data relating to this key performance indicator (KPI). From April 2019, data will be reported against the KPI for Children’s services in Doncaster Metropolitan Borough Council. In addition, these quality indicators are assessed as part of quality and contract meetings with key stakeholders.</td>
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<td>Trust Quality Priority</td>
<td>To holistically integrate physical and mental health care</td>
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<td>To assess the level of embedding of assessment of emotional health and well-being within Child and Adolescent Mental Health Service (CAMHS) service.</td>
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<tr>
<th>Trust Quality Priority</th>
<th>To create a single Trust-wide clinical quality information system.</th>
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<tr>
<td>Priority Area</td>
<td>Why is this important?</td>
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<td>To implement an integrated information dashboard system that improves the quality of service delivery, patient safety and standardises the operational processes and governance.</td>
</tr>
<tr>
<td>• Unity, Health Assure, Health Roster, Consequence UK, and Ulysses will work in collaboration to produce reporting and health record keeping systems.</td>
<td>By the end of 2018/19, SystmOne will be implemented in 100% of services within the Trust.</td>
</tr>
<tr>
<td>• Streamline to an integrated approach to information sharing with patients, staff and stakeholders via dashboards and data collection.</td>
<td>By the end of 2018/19, SystmOne will be implemented in 100% of services within the Trust.</td>
</tr>
<tr>
<td>Trust Quality Priority</td>
<td>To develop and implement a Quality Improvement (QI) model and methodology</td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Priority Area</strong></td>
<td><strong>Why is this important?</strong></td>
</tr>
<tr>
<td>To develop a Quality Improvement model, co-designed with staff, utilising their knowledge and experience of frontline services and the patient experience.</td>
<td>Establishing an LiA led Quality Improvement culture which is led collaboratively by front line employees and patients will ensure that sound improvements are identified and made where they are needed, when they are needed and by those who can own and influence the change.</td>
</tr>
<tr>
<td>Utilise the Listening into Action (LiA) approach as the vehicle for improving quality.</td>
<td></td>
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<td></td>
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<td></td>
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</tbody>
</table>
Measuring and reporting of the 2018/19 priorities for improvement

The following governance structure has been in place since 1 April 2018:

The reviewing, monitoring and measuring of quality (including the 2018/19 priorities for improvement) 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.
- Internal Audit reports.

**Quality Dashboard Reports**

Established in August 2016, the quality dashboards provide assurance internally and externally via the following routes (see Table 3 below).

Key:  
- Quality
- Transformation
- Finance and Performance
- People
## Table 3: Quality Dashboards

<table>
<thead>
<tr>
<th>Quality dashboard</th>
<th>Frequency</th>
<th>Internal assurance</th>
<th>External assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient safety</strong></td>
<td>Monthly</td>
<td>Care Group Governance meeting (Quality)</td>
<td>Doncaster Clinical Commissioning Group (CCG) Rotherham CCG and North Lincolnshire CCG Quality and Contract meetings (as appropriate).</td>
</tr>
<tr>
<td>• Incident reporting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Duty of Candour</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Serious incidents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Complaints and PALS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Restraint and Restrictive Intervention (RRI)</td>
<td>Quarterly</td>
<td>Care Group Governance meeting (Quality)</td>
<td>Doncaster Clinical Commissioning Group (CCG) Rotherham CCG and North Lincolnshire CCG Quality and Contract meetings (as appropriate).</td>
</tr>
<tr>
<td>• Falls*</td>
<td></td>
<td>Care Group Governance meeting (Quality)</td>
<td>Doncaster Clinical Commissioning Group (CCG) Rotherham CCG and North Lincolnshire CCG Quality and Contract meetings (as appropriate).</td>
</tr>
<tr>
<td>• Medicines Management</td>
<td></td>
<td>Quality Committee</td>
<td></td>
</tr>
<tr>
<td>• Pressure Ulcers*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Suicides</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Safeguarding Adults</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Safeguarding Children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Infection Prevention and Control (IPC).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*These areas are not included in the Children’s Care Group dashboard.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Clinical effectiveness and professional leadership</strong></th>
<th>Frequency</th>
<th>Internal assurance</th>
<th>External assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>• NICE guidance</td>
<td>Quarterly</td>
<td>Care Group Governance meeting (Quality)</td>
<td>Doncaster Clinical Commissioning Group (CCG) Rotherham CCG and North Lincolnshire CCG Quality and Contract meetings (as appropriate).</td>
</tr>
<tr>
<td>• Clinical Audit</td>
<td></td>
<td>Quality Committee</td>
<td></td>
</tr>
<tr>
<td>• Nursing and Midwifery Council (NMC)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Healthcare Professionals Council (HPC)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Non-Medical Prescribing (NMP)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• CQC.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Patient Engagement**                                  | Annual Report and six monthly assurance report | Quality Committee                     | Doncaster Clinical Commissioning Group (CCG) Rotherham CCG and North Lincolnshire CCG Quality and Contract meetings (as appropriate). |
| • Patient and Public Engagement and Experience (PPEE).   |           |                                                         |                                                                                     |
| • Volunteers                                            |           |                                                         |                                                                                     |
| • Carer Champions (including network).                   |           |                                                         |                                                                                     |
| • Listen to Learn                                       |           |                                                         |                                                                                     |
| • Triangle of Care                                       |           |                                                         |                                                                                     |
| • Family and Friend Test                                |           |                                                         |                                                                                     |

During 2018/19, the quality dashboard reports have been reviewed and work carried out to integrate and report on the ‘Quality of Care’ metrics (in line with and additional to the Single Oversight Framework (SOF) 2019/20) as part of the Trust’s Integrated Performance Dashboard from April 2019 via the following reporting framework:

- Level 1 – Regulatory (SOF)
- Level 2 – Internal assurance e.g. From Board, Committees and Care Group assurance meetings
- Level 3 – Operational management/reporting (via real time reporting).
Board Assurance Framework (BAF)

The Trust’s Board Assurance Framework (BAF) identifies strategic risks that may impact on the achievement of its strategic goals.

For 2018/19, there were four key quality risks identified which all related to the first strategic goal ‘To provide safe, effective compassionate care’:

• If we do not deliver care in line with quality and safety standards then this may lead to avoidable harm.
• If we do not identify learning when harm or potential harm does occur then there is a risk that we will not to provide safe, innovative care.
• If we do not have the right people, with the right skills, in the right place at the right time then there is a risk to the delivery of safe and effective care.
• If we do not foster positive relationships with partners and participate in environmental changes then we may fail to provide integrated and coordinated care to our service users.

The quality priorities are linked to one of the above risks and acts as a control to prevent the risk occurring. The progress and achievement of the quality priorities provide assurance on the mitigation of the risk.

The identified risks were regularly reviewed and monitored throughout 2018/19 by the Risk Lead, Executive Director of Nursing and Allied Healthcare Professionals (AHPs) and the Quality Committee, including gaps in the risk controls/assurance. Any ongoing gaps (and their associated actions) will be carried forward and continue to be monitored within the 2019/20 BAF.

Underpinning the strategic risks on the BAF are individual Directorate/Care Groups risk registers of relevant operational risks. Quality related risks are captured on the Nursing and Quality or Care Group Risk Registers and are regularly reviewed and monitored by the Quality Committee; all ‘extreme’ rated risks are also monitored by the Board of Directors on a monthly basis. The Executive Management Team reviews all risks regularly throughout the year to provide a ‘confirm and challenge’ function and to moderate the risks, in particular the ‘extreme’ risks. This review process also includes a rolling programme thematic review.

Monitoring of the BAF during 2018/19

Of the fourteen strategic risks within the BAF, three were assigned to the Quality Committee (remainder assigned to the Finance, Performance and Informatics Committee or to the Board of Directors). The three risks assigned to the Quality Committee were:

• If we do not deliver care in line with quality and safety standards then this may lead to avoidable harm.
• If we do not identify learning when harm or potential harm does occur then there is a risk that we will not to provide safe, innovative care.
• If we do not have the right people, with the right skills, in the right place at the right time then there is a risk to the delivery of safe and effective care.

Throughout the year the BAF has been populated with the assurances (and levels) received at the Board of Director and its Committees.

During the year the Quality Committee has reviewed the above risks in July, October 2018 and January 2019 and again in April 2019 to consider the assurances that have been received regarding the controls put in place to mitigate the strategic risks.

QR22
Summary Report from Quality Committee to Board

The Chair (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 monthly meeting.

Care Quality Commission (CQC) Inspection

During the period 11 January to 15 February 2018, the Care Quality Commission (CQC) undertook a planned ‘Well Led’ inspection of Rotherham Doncaster and South Humber NHS Foundation Trust with unannounced visits taking place from January 2018 and the inspection week 13-15 February 2018.

Following this inspection the Trust received an overall rating of ‘Good’, with ratings of ‘Good’ in the four domains of Effective Caring, Responsive and Well-Led and a rating of ‘Requires Improvement’ in the domain of Safe. In addition, the Trust received a total of five updated service level reports.

The inspection report was published in June 2018 with an overall rating of ‘GOOD’. The inspection report can be accessed via: https://www.cqc.org.uk/sites/default/files/new_reports/AAAH1451.pdf

The Trust’s ratings overall and at service level are identified in the figures below, along with comparative rating from the previous inspections in April 2016 and January 2015 (as indicated):
Figure 1: Trust Overall Rating and Service Level Ratings (June 2018)
Figure 2: Trust-Wide Ratings Comparative with Previous Inspection Results.

<table>
<thead>
<tr>
<th>Category</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist community mental health services for children and young people</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Requires</td>
<td>Improvement</td>
</tr>
<tr>
<td>Substance misuse services</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Wards for older people with mental health problems</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Wards for people with learning disabilities or autism</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>End of life care</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overall Trust Rating</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requires improvement, April 2018</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Apr 2018</td>
<td>Apr 2018</td>
<td>Apr 2018</td>
<td>Apr 2018</td>
<td>Apr 2018</td>
<td>Apr 2018</td>
<td>Apr 2018</td>
</tr>
</tbody>
</table>
Figure 3: Service Level Ratings Comparative with Previous Inspection Results.

### Ratings for mental health services

<table>
<thead>
<tr>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute wards for adults of working age and psychiatric intensive care units</strong></td>
<td>Requires Improvement Apr 2018</td>
<td>Good</td>
<td>Good</td>
<td>Requires Improvement Apr 2018</td>
<td>Good Apr 2018</td>
</tr>
<tr>
<td><strong>Long-stay or rehabilitation mental health wards for working age adults</strong></td>
<td>Requires Improvement Apr 2018</td>
<td>Good</td>
<td>Good</td>
<td>Requires Improvement Apr 2018</td>
<td>Good Apr 2018</td>
</tr>
<tr>
<td><strong>Forensic inpatient or secure wards</strong></td>
<td>Good Jan 2016</td>
<td>Good Jan 2016</td>
<td>Good Jan 2016</td>
<td>Good Jan 2016</td>
<td>Good Jan 2016</td>
</tr>
<tr>
<td><strong>Wards for older people with mental health problems</strong></td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td><strong>Community-based mental health services for adults of working age</strong></td>
<td>Requires Improvement Apr 2018</td>
<td>Good</td>
<td>Good</td>
<td>Requires Improvement Apr 2018</td>
<td>Good Apr 2018</td>
</tr>
<tr>
<td><strong>Mental health crisis services and health-based places of safety</strong></td>
<td>Good Jan 2016</td>
<td>Outstanding Jan 2016</td>
<td>Good</td>
<td>Outstanding Jan 2016</td>
<td>Good Jan 2016</td>
</tr>
<tr>
<td><strong>Specialist community mental health services for children and young people</strong></td>
<td>Good Jan 2017</td>
<td>Good Jan 2017</td>
<td>Good Jan 2017</td>
<td>Good</td>
<td>Good Jan 2017</td>
</tr>
<tr>
<td><strong>Community-based mental health services for older people</strong></td>
<td>Good Jan 2016</td>
<td>Outstanding Jan 2016</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td><strong>Community mental health services for people with a learning disability or autism</strong></td>
<td>Good Jan 2017</td>
<td>Good Jan 2017</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td><strong>Substance misuse services</strong></td>
<td>Requires Improvement Apr 2018</td>
<td>Good</td>
<td>Good</td>
<td>Requires Improvement Apr 2018</td>
<td>Good Apr 2018</td>
</tr>
</tbody>
</table>

### Ratings for community health services

<table>
<thead>
<tr>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community health services for adults</strong></td>
<td>Requires Improvement Jan 2016</td>
<td>Good Jan 2016</td>
<td>Good Jan 2016</td>
<td>Good Jan 2016</td>
<td>Good Jan 2016</td>
</tr>
<tr>
<td><strong>Community health services for children and young people</strong></td>
<td>Good Jan 2016</td>
<td>Good Jan 2016</td>
<td>Good Jan 2016</td>
<td>Outstanding Jan 2016</td>
<td>Outstanding Jan 2016</td>
</tr>
<tr>
<td><strong>Community health inpatient services</strong></td>
<td>Good Apr 2018</td>
<td>Good Apr 2018</td>
<td>Good Apr 2018</td>
<td>Good Apr 2018</td>
<td>Good Apr 2018</td>
</tr>
</tbody>
</table>
Contained within the published reports (June 2018) were a number of actions for the Trust to take forward, categorised as follows:

• Actions that the Trust MUST take to improve; and
• Actions that the Trust SHOULD take to improve.

An action plan was developed to address the areas of required action. The progress of this action plan has been regularly reviewed and monitored both internally and externally through the following groups:

• Board of Directors.
• Quality Committee.
• Executive Management Team.
• Local Safeguarding Boards.
• Commissioner Quality Meetings.
• CQC Engagement meetings.

**Internal Audit Reports**

During 2018/19, the Trust’s Internal Audit service (360 Assurance) has reported the following Internal Audits to Audit Committee relating to quality:

• Mortality – Learning from Deaths (September 2018).
• Quality Governance (January 2019).
• Incident Investigation (March 2019).
• Safer Staffing Data - Policy Compliance (November 2018).

The Trust received an Audit Opinion of ‘Limited Assurance’ for all of the above reports from 360 Assurance, who identified limited assurance ‘As a result of the 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. Our opinion is limited to the controls examined and samples tested as part of this 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 for Quality i.e. Executive Management Team and Quality Committee.
• There is an action plan in place for each audit to address the recommendations which arise from the audit results. These action plans have a responsible Executive Director and agreed time scales for completion.
• Monitoring of all action plans to ensure they are completed within the agreed timeframes.
2.2 Statements of assurance from the Board

Review of Services

During 2018/19 Rotherham Doncaster and South Humber NHS Foundation Trust provided and/or sub-contracted 62 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 62 of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19 represents 100% of the total income generated from the provision of relevant health services by Rotherham Doncaster and South Humber NHS Foundation Trust for 2018/19.

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/

Clinical Audit

National Clinical Audits/CQUINs 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 2018/19, 16 national clinical audits and 1 national confidential enquiry covered relevant health services that Rotherham Doncaster and South Humber NHS Foundation Trust provides.

During this period, Rotherham Doncaster and South Humber NHS Foundation Trust participated in 86.7% of the national clinical audits and 100% of the national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Rotherham Doncaster and South Humber NHS Foundation Trust were eligible to participate in during 2018/19 are shown in Table 4 below. This table also shows the number of cases submitted for each audit and as a percentage of the number of registered cases required by the terms of that audit.

<table>
<thead>
<tr>
<th>Table 4: Trust participation in national audits/CQUIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing Observatory for Mental Health (POMH-UK) Audits</td>
</tr>
<tr>
<td>Prescribing Observatory for Mental Health (POMH-UK) Audits</td>
</tr>
<tr>
<td>POMH UK - Topic 18a Use of Clozapine.</td>
</tr>
<tr>
<td>POMH UK - Topic 6d Assessment of the Side Effects of Depot Antipsychotics.</td>
</tr>
</tbody>
</table>

Clinical Audit

National Clinical Audits/CQUINs and Confidential Enquiries

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## National Audits

<table>
<thead>
<tr>
<th>Audit Title</th>
<th>Lead</th>
<th>Number of cases submitted</th>
<th>% cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Clinical Audit of Anxiety and Depression (NCAAD)</td>
<td>Modern Matron (Donc) Clinical Nurse Co-ordinator (North Lincs.) Nurse Consultant Rotherham</td>
<td>100</td>
<td>100%</td>
</tr>
<tr>
<td>National Audit of Care at the End of Life (NACEL)</td>
<td>Associate Nurse Directors for Rotherham and Doncaster and Modern Matron (N.Lincs)</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>National Diabetes Foot Care Audit</td>
<td>Podiatry Lead</td>
<td>50</td>
<td>100%</td>
</tr>
<tr>
<td>National Clinical Audits (NCAs) (NCAAP) – EIT spotlight audit</td>
<td>Service Manager (Donc) Clinical Nurse Co-ordinator (North Lincs.) Nurse Consultant Rotherham</td>
<td>190</td>
<td>100%</td>
</tr>
<tr>
<td>National Clinical Audits (NCAs) (NCAAP) – Psychological Therapies spotlight audit</td>
<td>Service Manager</td>
<td>30</td>
<td>100%</td>
</tr>
</tbody>
</table>

## National CQUIN

<table>
<thead>
<tr>
<th>Audit Title</th>
<th>Lead</th>
<th>Number of cases submitted</th>
<th>% cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>National CQUIN - 3a Cardio Metabolic Assessment and Treatment for patients with Psychosis Part A - Early Intervention Teams</td>
<td>CQUIN Programme Manager</td>
<td>190</td>
<td>100%</td>
</tr>
<tr>
<td>National CQUIN - Improving the Assessment of Wounds (Re-audit)</td>
<td>Tissue Viability Nurse Specialist</td>
<td>150</td>
<td>100%</td>
</tr>
<tr>
<td>National CQUIN - 3a Cardio Metabolic Assessment and Treatment for patients with Psychosis Part A Inpatients / CMHT</td>
<td>CQUIN Programme Manager</td>
<td>150</td>
<td>100%</td>
</tr>
<tr>
<td>National CQUIN - Mental Health 3b (MH9b) Communication with GP - Part B. Collaboration with primary care clinicians</td>
<td>CQUIN Programme Manager</td>
<td>93</td>
<td>100%</td>
</tr>
<tr>
<td>National CQUIN - Improving the Assessment of Wounds (Re-audit)</td>
<td>Tissue Viability Nurse Specialist</td>
<td>150</td>
<td>100%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Audit Title</th>
<th>Lead</th>
<th>Number of cases submitted</th>
<th>% cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Mental Health Clinical Outcome Review Programme</td>
<td>Medical Director</td>
<td>This data is submitted directly to the National team by the Care Groups.</td>
<td>100%</td>
</tr>
</tbody>
</table>
As a result of transition to UNITY system across the Trust, there has been an inability to migrate/extract data across for reporting. Therefore, Rotherham Doncaster and South Humber NHS Foundation Trust did not participate in the Sentinel Stroke National Audit Programme (SSNAP). Therefore, no data was collected for this audit during 2018/19.

POMH audits are conducted through the Royal College of Psychiatrists and are seen as national benchmarking audits in prescribing for mental health.

**POMH Audits**

The reports of three out of three national clinical audits were reviewed by the provider in 2018/19 and Rotherham Doncaster and South Humber NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (via the Medicines Management Committee (MMC), who received and discussed relevant actions for the following POMH audits):

**POMH UK 17A (Baseline POMH audit) – The use of depot and long acting antipsychotic injections (LAI) for relapse prevention**

The Trust submitted data for 309 patients from across the three relevant care groups, involving 11 wards and seven community mental health teams. This is a baseline audit and so there are no comparisons to previous results. From the report we considered the following audit criteria and aspects of care:

- Care planning for patients on depots and LAIs.
- Prescribing and review of LAIs for patients.

Overall the result was GOOD using the Trust evaluation criteria and against the national results in the areas of:

- Including the patient in the decision making, recording rationale for treatment and review of therapeutic response.
- Crisis plans being included in the patient record.

Areas for improvement were identified as:

- Ensuring there is a clinical plan should a patient fail to attend for their injection.
- Embedding the recording of the annual review.

**POMH UK - Topic 15b Prescribing valproate for bipolar disorder**

The Trust submitted data for 136 patients from across the three relevant care groups, involving four wards and four community mental health teams. This was repeat audit and looked at the use of valproate in patients with the potential for falling pregnant and monitoring throughout treatment. The audit demonstrated:

Areas of good practice:

- A reduction in the number of female patients under 50 years of age on valproate.
- An increase in the annual monitoring of physical health parameters for patients with longer term treatment.

An area for improvement:

- The need for more robust recording of monitoring by a small number of teams in the first 6 months of treatment.
POMH UK - Topic 6d - Assessment of the side effects of the depot antipsychotics

This audit did not take place nationally in quarter 4 2018/19 as scheduled.

National Parkinson’s Audit

Data collection has been completed for this audit and awaiting the national report.

Diabetic Foot Care

Data collection has been completed for this audit and awaiting the national report.

National Clinical Audit of Psychosis (NCAP)

The Trust submitted data for 147 patients across the three relevant care groups, involving 11 teams. The aggregated results for this audit have been received back into the Trust and an analysis is being conducted to allow for individual teams performance against Trust and national result.

Trust (local) Clinical Audits

A total of 41 local clinical audits have been completed during 2018/19 as follows in Table 5:

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Total Completed Audits Reported</th>
<th>Outstanding</th>
<th>Good</th>
<th>Requires Improvement</th>
<th>Inadequate</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>3*</td>
</tr>
<tr>
<td>2</td>
<td>11</td>
<td>0</td>
<td>4</td>
<td>6</td>
<td>0</td>
<td>1*</td>
</tr>
<tr>
<td>3</td>
<td>11</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td>0</td>
<td>2*</td>
</tr>
<tr>
<td>4</td>
<td>10</td>
<td>0</td>
<td>7</td>
<td>2</td>
<td>0</td>
<td>1*</td>
</tr>
<tr>
<td>Year-End Total</td>
<td>41</td>
<td>0</td>
<td>20</td>
<td>14</td>
<td>0</td>
<td>7</td>
</tr>
</tbody>
</table>

* Provided by the National Audit Team

The reports of all 41 local clinical audits were reviewed by the Trust in 2018/19 and the following actions have been taken to improve the quality of healthcare provided through the continuous improvement of systems and processes.

Examples of improvements to the clinical audit process during 2018/19 include:

• All the Trust’s clinical audit facilitators are allocated to one of the four Care Groups. These arrangements have been beneficial to building and establishing good working relationships with operational colleagues and staff engagement.

• Responsibility for audit action plan development is the audit lead(s) and Care Group with support provided by the clinical audit facilitator when required.

• Ownership of the audit actions plans is held at a local level within the services and is monitored by the Clinical Audit Department to ensure completion and collation of evidence for assurance.

• Each Care Group receives a monthly ‘audit progress report’ (produced by the clinical audit facilitator) to their respective Care Group assurance meeting (for quality) for review (including scrutiny and challenge) and monitoring. The report includes all forthcoming audits and assurance/ exceptions to ongoing and completed audits the Care Group are involved in.

• From the locality Care Group quality meeting, the findings, including highlights/ exceptions, are reported through the governance structures to Quality Committee and on to Trust Board via the clinical audit dashboards, summary reports and annual work programme.

• An audit action plan review process was implemented during 2018/19 in accordance with the overall audit rating, the clinical audit facilitator will conduct an action plan review with the audit lead as follows:
<table>
<thead>
<tr>
<th>Outcome Rating</th>
<th>Rationale</th>
<th>Audit Follow Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outstanding</td>
<td>Achieved 100% across all standards.</td>
<td>A self-audit to be conducted by the service in the forthcoming year.</td>
</tr>
<tr>
<td>Good</td>
<td>Achieved 75% to 99.9% to most standards.</td>
<td>A face to face 6 months ‘action plan review’ visit (announced) with the clinical audit facilitator and audit lead.</td>
</tr>
<tr>
<td>Requires Improvement</td>
<td>Achieved 50 – 74.9% to most standards or mixed results.</td>
<td>The clinical audit facilitator to conduct an unannounced ‘action plan review’ visit within three months of issuing the audit report.</td>
</tr>
<tr>
<td>Inadequate</td>
<td>Achieved 49.9% or below for most standards.</td>
<td>The clinical audit facilitator to conduct an unannounced ‘action plan review’ visit within one month of issuing the audit report.</td>
</tr>
</tbody>
</table>

**Clinical Research**

The number of patients receiving relevant health services provided or sub-contracted by Rotherham Doncaster and South Humber NHS Foundation Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee and on the National Institute of Health Research portfolio was 1752 against a target of 600 (as of 22 February 2019). The end of year figure is due on 15/5/19.

**Commissioning for Quality and Innovation (CQUIN)**

A proportion of the Rotherham Doncaster and South Humber NHS Foundation Trust income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between Rotherham Doncaster and South Humber NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

This equates to 2.5% of the Rotherham Doncaster and South Humber NHS Foundation Trust income in 2018/19, equivalent to £2,785,660 compared to the 2017/18 income which was £2,790,450.

The actual CQUIN received in 2018/19 was £2,697,473 (97% of potential CQUIN).

Further details of the National CQUIN schemes for 2019/20 are available electronically via the NHS England web page at: https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/

**Care Quality Commission (CQC) Registration**

Rotherham Doncaster and South Humber NHS Foundation Trust are 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 2018/19 reporting period:

- There are no conditions in place.
- 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.

CQC conducted a ‘Well Led’ inspection at the Trust; with unannounced visits taking place from January 2018 and the inspection week 13-15 February 2018. The inspection report was published on 28 June 2018 with an overall rating of GOOD. This report can be found at http://www.cqc.org.uk/provider/RXE

**Data Quality**

Rotherham Doncaster and South Humber NHS Foundation Trust submitted records during 2018/19 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 99.7% 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 62% for admitted patient care (not applicable for outpatient care and for accident and emergency care).

The national NHS Digital ‘Information Governance Toolkit’ has been superseded by the ‘Data Security and Protection Toolkit’ which reports whether standards ‘have’ or ‘have not’ been met from NHS Provider submissions. Rotherham Doncaster and South Humber NHS Foundation Trust has submitted the completed toolkit for 2018/19 to NHS Digital with an overall score of limited assurance against the required standards. The Trust has submitted an improvement plan which is awaiting approval from NHS Digital.

Rotherham Doncaster and South Humber NHS Foundation Trust were not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

During 2018/19 Rotherham Doncaster and South Humber NHS Foundation Trust completed the following action to improve data quality, with TPP implemented across 100% of its services.

The creation of an integrated Electronic Patient Record which has delivered the opportunity for more timely, consistent and accurate data capture in patient records. During 2018/19, the implementation of a single electronic patient record concluded. This has not only enabled record shares across the Trust and primary care services, but also enables development towards achieving the regional health record.

The process for implementation also enabled a robust staff training programme to support improvements in data entry processes to support contemporaneous records. This has already started to improve the quality of information to support the delivery of care and the accuracy of performance and activity reporting.

The Trust has also taken the opportunity presented in harmonising onto a single patient record to improve the overall reporting and assurance process to support maintenance of a standardised recording and reporting profile and build trust in the data and its accuracy.

**Our assessment of the impact of the actions taken in 2018/19 as described above which were taken by Rotherham Doncaster and South Humber NHS Foundation Trust during 2018/19:**

• All Care Groups have now implemented the new TPP SystmOne integrated electronic patient record system. This has already delivered significant positive benefits e.g. it has enabled the sharing of clinical records across the Trust teams and primary care/GP services and it has supported a robust programme of staff training which has improved data entry and accuracy.

• An audit of risk assessment has revealed a significant improvement in compliance with risk assessment document completion.
Learning from deaths

During 2018/19, 145 of Rotherham Doncaster and South Humber NHS Foundation Trust patients died where the Trust was identified as the main care provider (definition available in the Trust’s Learning from Deaths policy available on the public website). Table 6 below comprises the following number of deaths which occurred in each quarter of 2018/19 and the number of case record reviews and investigations undertaken.

<table>
<thead>
<tr>
<th></th>
<th>Q1 2018/19</th>
<th>Q2 2018/19</th>
<th>Q3 2018/19</th>
<th>Q4 2018/19</th>
<th>Total 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of deaths</td>
<td>31</td>
<td>33</td>
<td>32</td>
<td>49</td>
<td>145</td>
</tr>
<tr>
<td>Number of case record reviews</td>
<td>22</td>
<td>25</td>
<td>22</td>
<td>34</td>
<td>103</td>
</tr>
<tr>
<td>Number of investigations (By Serious Investigation process)</td>
<td>9</td>
<td>8</td>
<td>10</td>
<td>15</td>
<td>42</td>
</tr>
</tbody>
</table>

By 31 March 2019, 103 case record reviews and 42 serious incident investigations have been carried out in relation to the 145 deaths included in Table 6 above. Of the 42 serious incident investigation reviews 19 are still ongoing.

A summary of the learning and actions taken by Rotherham Doncaster and South Humber NHS Foundation Trust in relation to the findings and outcomes of the case record reviews and investigations include:

The second version of the Trust’s Learning from Deaths Policy was ratified by the Board of Directors on 28 March 2019. Up to this point the Trust had agreed with the Northern Alliance Group of Trusts (13 Trusts covering the North of England, North Sheffield up to the Border of Scotland) that due to the complexity of determining problems in care which led to a death in a mental health and community trust, we would agree this was a work in progress in terms of working on systems and processes along with definitions that might enable us to address this point.

The second version of the Trust’s Policy has a clear process for determining whether a death was due to a problem in care, which will result from a formal structured judgement review led by a trained reviewer in consultation with the multi-disciplinary team who provided care for the patient prior to death.

All mortality screens and structured judgement reviews will be reviewed on a weekly basis by a newly formed group called the Mortality Operational Group which will then feed into the monthly Mortality Surveillance Group up through to the Quality Committee, a sub-committee of the Trust Board and then on to the Board of Directors. Data on this will be included in the quarterly report that goes to the Board of Directors starting Quarter 1 2019/20.

2.3 Reporting Against Core Indicators

In accordance with the NHS (Quality Accounts) Amendment Regulation 2017 core set of quality indicators; the Trust is required to report against these within the Quality Report. The inclusion of these mandated indicators enables Rotherham Doncaster and South Humber NHS Foundation Trust to provide data that is benchmarked against the national average performance of other mental health trusts. We have reviewed these indicators and our position against all relevant indicators for 2018/19 is as follows.

Where available, data is taken from national data sources and whether it is governed by standard national definitions. Data sources are referenced in Tables 7-9 below.
**Table 7:** 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.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>RDaSH Source: NHS England</td>
<td>96.9%</td>
<td>96.43%</td>
<td>95.75%</td>
</tr>
<tr>
<td>All England highest/lowest Source: NHS England</td>
<td>100%/68%</td>
<td>100%/74.23%</td>
<td>99.4/88.9%</td>
</tr>
<tr>
<td>All England Average Source: NHS England</td>
<td>95.5%</td>
<td>96.08%</td>
<td>98.8%</td>
</tr>
</tbody>
</table>

*The reported data for this indicator continues to be validated following submission to NHS England and therefore varies from that published.


**Assurance Statement:**

RDaSH have consistently achieved the 95% target set by NHS Improvement. Whilst a slight decline can be seen in compliance during 2018/19 compared to the previous 2 years, assurance can be provided that work is underway to support improvement moving into 2019/20.

We have as an organisation selected this metric (chosen by the Council of Governors) as one for external audit review in order to provide a level of independent assurance, with defined improvement actions to support enhanced delivery during 2019/20. The external auditors report (Annex 4) has highlighted improvement areas in respect of this metric and the Trust has agreed actions to be taken to strengthen the input, collation and reporting processes.

**Table 8:** The percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>RDaSH Source: NHS England</td>
<td>95.75%</td>
<td>96.43%</td>
<td>97.3%</td>
</tr>
<tr>
<td>All England highest/lowest Source: NHS England</td>
<td>100%/90%</td>
<td>100%/74.23%</td>
<td>100%/93.7%</td>
</tr>
<tr>
<td>All England Average Source: NHS England</td>
<td>98.8%</td>
<td>96.08%</td>
<td>98.7%</td>
</tr>
</tbody>
</table>

*The reported data for this indicator continues to be validated following submission to NHS England and therefore varies from that published.


**Assurance Statement:**

RDaSH has performed consistently high against this metric, delivering a year on year improvement. Work continues to support care to be provided in alternatives to bed based services and we have demonstrated a clear commitment in our organizational strategy to ensure care closer to home, a fundamental principle which is at the core of discussions and service developments with or commissioners.
Table 9: The percentage 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.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients readmitted to hospital within 28 days of being discharged aged 0-15</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Number of patients readmitted to hospital within 28 days of being discharged aged 16 and over</td>
<td>120</td>
<td>122</td>
<td>82</td>
</tr>
</tbody>
</table>

Assurance Statement:

RDaSH have demonstrated a significant reduction in readmissions during 2018/19. Pathways both in and out of bed based services remains an area of focus. We continually strive to ensure safe and effective transitions with appropriate handover and ongoing health and social care engagement to provide support appropriate to individual needs and prevent any unnecessary readmission requirements.

In summary

Rotherham Doncaster and South Humber NHS Foundation Trust consider that this data is as described (in Tables 7-9) 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 (2019/20):

- Regular checks of the raw data for accuracy (prior to submission) are carried out by the Trust’s Performance Team.
- The Trust’s Information Quality Officer undertakes a programme of data quality audits.
- Finalisation of the Unity Project, introducing an integrated Electronic Patient Record across the Trust, including associated training for staff on data entry.

Table 10: 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 – patient experience of contact with a health or social care worker during the reporting period.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Trust 2018 Score</th>
<th>Comparison to overall 2018 national score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were you given enough time to discuss your needs and treatment?</td>
<td>77.1%</td>
<td>80%</td>
</tr>
<tr>
<td>Did the person or people you see understand how your mental health needs affect other areas of your life?</td>
<td>71.6%</td>
<td>74.5%</td>
</tr>
</tbody>
</table>

Source: CQC Mental Health Community Services Survey 2018

Assurance Statement:

The Trust has one of the top 20% scores for service users reporting they were given enough time to discuss their needs and treatment. Some service users report their health or social care worker did not fully understand how their mental health need affected other areas of their life. The RDaSH is at the top end of the intermediate range and both scores are an improvement on 2017.

Rotherham Doncaster and South Humber NHS Foundation Trust will take the following actions to improve this score:

- The themes/trends and recommendations of the report are reviewed and agreed at the locality Care Group Quality Governance meetings.
- Each Care Group are to develop a quality improvement plan from the outcomes of the survey.
- The Mental Health Community Services Survey 2018 report is submitted to the Trust’s Operational Management Meeting (OMM).
Table 11: 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 (Ref. National Reporting and Learning System (NRLS) categorisation).

<table>
<thead>
<tr>
<th>Patient Safety Incidents (PSI)</th>
<th>01/04/18 to 30/09/18 RDaSH NRLS Data</th>
<th>01/04/18 to 30/09/18 All MH Trusts NRLS Data</th>
<th>01/04/18 to 30/09/18 All NHS Trusts NRLS Highest/Lowest</th>
<th>01/10/17 to 31/03/18 RDaSH NRLS Data</th>
<th>01/10/17 to 31/03/18 All MH Trusts NRLS Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of patient safety incidents</td>
<td>2089</td>
<td>3381</td>
<td>9204/1129</td>
<td>1850</td>
<td>3160</td>
</tr>
<tr>
<td>% Rate per 1000 bed days</td>
<td>42.73%</td>
<td>55.4%</td>
<td>65.8%/33.9%</td>
<td>35.36%</td>
<td>51.3%</td>
</tr>
<tr>
<td>Total number of deaths</td>
<td>48</td>
<td>51</td>
<td>65/09</td>
<td>32</td>
<td>31</td>
</tr>
<tr>
<td>Total number of severe patient safety incidents</td>
<td>0</td>
<td>50</td>
<td>12/0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>% of PSI resulting in death</td>
<td>2.3%</td>
<td>3.58%</td>
<td>0.7/0.8%</td>
<td>1.73%</td>
<td>3.25%</td>
</tr>
<tr>
<td>% of PSI resulting in severe harm</td>
<td>0%</td>
<td>0.3%</td>
<td>0.1/0.0%</td>
<td>0.05%</td>
<td>0.10%</td>
</tr>
</tbody>
</table>

Source: National Reporting and Learning System (NRLS)

Assurance Statement:

Rotherham Doncaster and South Humber NHS Foundation Trust consider that this data is as described (in Table 11) for the following reason:

- The Trust has continued to promote a culture which encourages the reporting of incidents.
- The Trust's number of incidents resulting in death has decreased in 2018/19 and is below the national average.
- The number of incidents resulting in severe harm has decreased and is below the national average.

Rotherham Doncaster and South Humber NHS Foundation Trust has taken the following actions, to improve the quality of its services, by reviewing all deaths and the learning from death:

- All deaths are reviewed by the Mortality Surveillance Group and findings reported to Trust Board through the Governance structures in order to gain assurance.
- Action plans are agreed (as appropriate) and are reviewed by our commissioners in line with the national Serious Incident Framework.
- Implementing a mortality module on the Ulysses system to effectively report and monitor deaths.
- Implement actions as a result of an internal audit into learning from deaths undertaken by 360 Assurance during 2018/19.
Part 3

This section provides an overview of the quality of care delivered by Rotherham Doncaster and South Humber NHS Foundation Trust; based on the performance in 2018/19 against indicators selected by Trust Board in consultation with stakeholders.

The following is a summary of the key indicators for each of the three quality domains and ‘our people/staff’ domain.

3.1 Patient safety

Reported incidents

The total number of incidents reported by the Trust is 9331. Learning from incidents is reported through the Trust’s quality Governance structures, to drive quality standards and service improvements.

A key priority for 2019/20 is to continue to implement robust systems and processes to enable shared/organisational learning from reported incidents across the Trust. Table 12 below details the number of incidents by level of harm.

<table>
<thead>
<tr>
<th>Reported incident - level of harm</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – Near miss</td>
<td>1011</td>
<td>904</td>
<td>977</td>
</tr>
<tr>
<td>1 – No harm</td>
<td>5318</td>
<td>4522</td>
<td>4475</td>
</tr>
<tr>
<td>2 – Minor (minimal harm)</td>
<td>3745</td>
<td>3116</td>
<td>3411</td>
</tr>
<tr>
<td>3 - Moderate (not permanent harm)</td>
<td>319</td>
<td>267</td>
<td>286</td>
</tr>
<tr>
<td>4 - Major (not permanent harm)</td>
<td>33</td>
<td>21</td>
<td>19</td>
</tr>
<tr>
<td>5 - Catastrophic (permanent harm)</td>
<td>8</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>6 - Death</td>
<td>160</td>
<td>134</td>
<td>160</td>
</tr>
<tr>
<td>Total</td>
<td>10594</td>
<td>8970</td>
<td>9331</td>
</tr>
</tbody>
</table>

Assurance Statement:

During the period 1 April 2018 to 31 March 2019 the Trust incident figures are taken from the National Reporting and Learning System (NRLS) organisational categorisations and data reports.

The Trust engaged in the Listening in Action programme during 2018/2019 in terms of improving incident reporting. As a result of this engagement work the Trust has taken the following actions to improve the number of incidents reported and so improve the quality and safety of its services by:

- Making improvements to the Trust incident reporting system Ulysses to give staff better access and user friendly.
- Adding a mortality module to separate natural and/or expected deaths from incidents.
- Providing access to real-time information on Ulysses dashboards.
- Embracing new technological ideas in improving the incident reporting system.
- Identifying areas of low reporting and devising strategies for improvement.
- Improve training on incident reporting to staff.
- Implement actions based on recommendations made in the internal audit report of incidents performed during 2018/19 by Internal Audit (360 Assurance).
Serious incidents

In 2018/19, Rotherham Doncaster and South Humber NHS Foundation Trust reported a total of 62 serious incidents on Strategic Executive Reporting System (STEIS). Table 13 below identifies how this figure compares to the serious incidents during 2017/18 and 2016/17. This figure includes four cases awaiting moderation from April’s pressure ulcer panel.

Table 13: Serious Incident Numbers Reported on STEIS

<table>
<thead>
<tr>
<th>STEIS Serious Incident (SI)</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number STEIS reported SIs</td>
<td>103</td>
<td>78</td>
<td>62</td>
</tr>
</tbody>
</table>

Assurance Statement:

The Trust reports all serious incidents supported by a culture of being open and honest.

During 2018/2019 serious incident investigations are managed by the Head of Patient Safety and investigated by a team of Investigation Leads in partnership with the Care Groups. This provides continuity of approach to investigations and enables the Trust to learn and make changes to services to improve quality and safety. As part of the statutory Duty of Candour, the Trust shares lessons that are learned as a result of investigations into serious incidents with the patient and/or family.

During 2018/2019 the Trust’s Freedom to Speak-up Guardian and supporting advocates have continued to provide a confidential service to enable staff to raise concerns.

The serious incidents reported in 2017/18 were categorised as follows:

Serious Incidents Categories reported 2018/19

- Apparent/actual/suspected self inflicted harm: 43
- Pending review: 7
- Pressure ulcer: 7
- Disruptive/aggressive/violent behaviour: 1
- Slipos/trips/falls: 1
- Confidential information leak: 1
- Abuse/alleged abuse of adult patient by third party: 1
**Never events**

‘Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers’ (NHS Improvement, 2018). During 2018/19, the Trust has had zero (0) never events.

**Patient safety incidents**

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

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

- Patient accident/incident.
- Adverse health event (an injury related to medical management. Medical management includes all aspects of care, including diagnosis and treatment, failure to diagnose or treat, and the systems and equipment used to deliver care. Adverse events may be preventable or non-preventable).

**Duty of Candour**

The Duty of Candour (DoC) applies to ALL patient safety incidents which have an actual impact of ‘Moderate’ or higher. If DoC is applicable, the following actions required and completed to comply with DoC:

- A nominated person contacts the patient or relevant person.
- The nominated person provides an apology and a full explanation of what has happened and what will happen next.
- A letter is sent to confirm this conversation.
- The nominated person or delegate investigates the incident and writes a report.
- A copy of the report and explanation of the report (if required) is provided to the patient or relevant person.
- These actions are recorded on the Trust’s ‘Ulysses’ incident reporting system and copies of all written correspondence are attached to the incident report.

During 2018/19, the Trust’s Head of Patient Safety and the Trust Medical Devices and Projects Officer has provided advice and guidance for staff on DoC and are also responsible for monitoring DoC incidents. They also provide a prompting service to ensure that managers are aware of the requirements.

**Organisational learning**

This Cultural Development and QI model builds upon the strong foundations concerning enjoyment, improvement and co-production developed via the use of the Listening into Action approach over the past three years. It provides a more digitally enabled approach, utilising ‘Quality, Service Improvement and Redesign’ (QSIR) Programme methodologies, underpinned with the ‘Culture and Leadership’ approach supported by NHS Improvement. Transitioning into this model is planned throughout 2019/20 supported by a structured training and accreditation programme, and a focused ‘wrap-around’ suite of cultural support approaches.
introduction of ‘Schwartz Rounds’, ‘human factors’ working and enhanced support Equality, Diversity and Inclusion activity.

Rotherham Doncaster and South Humber NHS Foundation Trust learn from a range of sources including patient and staff feedback, outcomes of reported incidents and innovations.

Organisational learning takes place at a locality level within each of the Care Groups and at a Trust-wide level:

- **Care Group**

  Learning takes place via locality manager/team meetings, where themes/trends are reviewed and reported through the relevant governance structures for quality, safety, financial regulation and staff management.

- **Trust-wide**

  - The Trust’s ‘Leadership Development Forum’ is responsible for providing a structured approach to organisational learning and improvement discussions. Incidents and developments are discussed, reflected on and shared in order to learn from these and embed this learning in the Trust’s culture and practice.

  - There are plans to introduce a ‘Learning Matters’ forum alongside of the Leadership Development Forum in 2018/19. It is anticipated that this will further foster a culture of ‘learning and not blaming’, in which a ‘safe space’ is provided to explore concerns, incidents, failures and successes from each of the Care Groups. It will also ensure best practice can be shared and lead to reduced variation in service provision. This is currently under development by the Nursing and Quality Team and trial forums have been conducted.

**Safeguarding**

NHS Trusts are required to have in place arrangements that reflect the importance of safeguarding and promoting the welfare of children. These include senior management commitment and accountability at all levels across the organisation for safeguarding, with suitable experienced leadership, a culture of listening to children and adults at risk, a culture where staff have the freedom to speak up about practice that concerns them, arrangements in place whereby concerns about multi agency work can be escalated swiftly and resolved to ensure children, young people and adults at risk remain safe. The Trust should have clear processes in place for information sharing within the context of safeguarding children and adults at risk. Recruitment practices and retention of a safe and expert workforce is vital. Staff should be supported and trained to deliver safe care as well as demonstrate excellent practice. In addition those who would harm a child, young person or adult at risk are discouraged from the organisation.

As part of demonstrating its commitment to meeting the arrangements described above the Trust completes an annual self-declaration and also assessments requested by Local Safeguarding Children Boards (or their replacements) on compliance with duties outlined in section 11 of the Children Act 2004. Details of the full declaration submitted by Rotherham Doncaster and South Humber NHS Foundation Trust are available on the Trust website: http://www.rdash.nhs.uk/about-us/public-declarations/safeguarding/

**Training**

Rotherham Doncaster and South Humber NHS Foundation Trust had (and has) an up to date safeguarding children and safeguarding vulnerable adults training strategy and training programme available to all staff. To support staff identify which staff require what level of safeguarding training a guide for managers has been developed. Multi-disciplinary training continues to be delivered across the Trust at all levels. Training compliance is shown in Table 14:
Table 14: Safeguarding Training (Level 1) Compliance

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children</td>
<td>92.9%</td>
<td>94.61%</td>
<td>98.6%</td>
</tr>
<tr>
<td>Safeguarding Adults</td>
<td>88.71%</td>
<td>90.61%</td>
<td>98.6%</td>
</tr>
</tbody>
</table>

Source: Oracle Learning Management System

Following the publication of the Intercollegiate document for safeguarding children and young people and for safeguarding adults the Trust has reviewed the training and development offer to staff and the revised training and development programme for 2019-2022 is available on the trust website. In addition the Trust works with Local Safeguarding Children’s Boards and Safeguarding Adult Boards to ensure that there are sufficient training opportunities for staff to engage in multi-agency training.

Each year the Trust publish an Annual Safeguarding Report that outlines the collaboration with Local Safeguarding Children Boards and Safeguarding Adult Boards, the Trust safeguarding priorities under the priorities set within the Five Year Strategy. The Trust is currently producing the Annual Safeguarding report which will provide detail on the progress made in these areas over 2018/19.

Work with local Safeguarding Children Boards and commitment local priorities

The Trust works effectively with three Local Safeguarding Boards and three Safeguarding Adult Boards. The Trust ensures that there is appropriate representation on all Boards and associated subgroups and commits to a total of 48 different types of Boards and sub groups over the three locality areas. The Nurse Consultant and Named Nurses have a key role in promoting good professional practice within the organisation.

Looked After Children (LAC) Doncaster

During 2018/19, the Looked After Children’s (LAC) Team has continued to develop the quality of services delivered to Looked After Children and their carers including:

- Development of a dedicated 0-19 LAC team, focusing on the quality improvement for looked after children and their carers.

Each Looked After Child is allocated a named nurse, providing consistency and continuity throughout the care period. This enables therapeutic relationships to be established and ensures that Looked After Children do not have to keep repeating their stories which are often traumatic. This model is viewed as best practice within the South Yorkshire and Bassetlaw regional network and is in the process of being rolled out in other authorities.

- The commissioning of Joint Initial Health Assessment for Looked After Children following a successful business case being put forward by the LAC team

The nurse led contribution to the initial health assessments ensure that all health needs are identified as part of a holistic, child/young person centred (and no longer a medical model) approach to care. The named nurse oversees the health care plan to ensure health outcomes are improving.

- Professionals learning through young people’s experiences in care

The Named Nurse for looked after children arranged the delivery of ‘Total Respect’ training to practitioners within RDaSH who work directly with Looked After Children, Young People and Care Leavers. ‘Total Respect’ training is delivered by young people who have been in care with the philosophy that young people are both the experts and the leaders; it aims to challenge and change attitudes and stereotypes about care. It allows participants to understand the experiences of young people who use their service, to get participants to ‘walk in their shoes’.

The above group was formulated in response to the guidance produced by NHS England “A guide to meeting the statutory health needs of Looked After Children through a standard approach to commissioning and service delivery” (NHS England, November 2017). A Safeguarding bid was completed to support the work of the group.
in reducing unwarranted variation that exists for Looked After Children across South Yorkshire and Bassetlaw. The groups consist of designated and named professionals across health and social care with the aim of:

- Working together to consider the health needs of children in care across the South Yorkshire and Bassetlaw region.
- Ensuring that individual group members retain responsibility for disseminating information and guidance within sub regions.
- Sharing best practice and working towards all children in care receiving an equitable service based on need.

As part of this work stream a task and finish group has been instrumental in reviewing and streamlining the Review Health Assessment tool for LAC. The aim is to reduce time spent on documentation and improve quality and efficiency. This will be piloted and evaluated by Doncaster and South Yorkshire & Bassetlaw LAC team teams during 2018-19***.

RDaSH Named Nurse for Looked After Children was asked to present the Doncaster 0-19 LAC approach to the steering group as this was identified as a best practice model. As a result of this other areas within the region are looking to adopt RDaSH's dedicated team approach.

*** The new documentation has been implemented and feedback has been positive so far. This has been identified via peer review of Review Health Assessments within the LAC team.

**Infection Prevention and Control**

Infection Prevention and Control (IPC) remains one of the Trust's key priorities. Reducing health care associated infections (HCAIs) is high on the Government's safety agenda and a priority for the general public in their expectations of the quality of care they received.

Table 15 below identifies Rotherham Doncaster and South Humber NHS Foundation Trust's number of HCAI notifications in 2018/19 and a comparison to previous years; and shows that infection rates within the Trust remain low.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Escherichia coli (E. coli) bacteraemia</td>
<td>1</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemia</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Meticillin Sensitive Staphylococcus aureus (MSSA) bacteraemia</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Clostridium difficile infection (CDI)</td>
<td>10</td>
<td>5</td>
<td>5*</td>
</tr>
</tbody>
</table>

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

**E. coli Bacteraemia**

During 2018/19, the Trust has had one case of E.coli reported (March 2019). The internal post infection review for this case is currently ongoing.

**Clostridium difficile infection (CDI)**

*Each CDI case has been reviewed and a root cause analysis investigation undertaken. It was found that all cases were 'unavoidable' with no lapses in care. Any shared/ organisational learning e.g. record keeping, obtaining samples and staff training are identified through an action plan been developed and implemented for the ward concerned.
3.2 Clinical Effectiveness

Clinical Audit

Annual Clinical Audit Programme

The Trust has an annual clinical audit programme, the activity and delivery of which is reported on a quarterly basis to the Trust's Quality Committee. The programme includes:

- All the national audits (including POMH-UK) which the Trust is eligible to participate in.
- All local (Trust) audits submitted by each of the Care Groups.
- Relevant CQUINs which require clinical audit support for delivery.

The annual programme is fluid, with audits added and removed in response to changing circumstances e.g. national audit team advice, Quality Improvement action. The Trust’s Senior Clinical Audit Practitioner has oversight and operational responsibility for the annual programme; and is experienced in “flexing” the forward programme to re-prioritise as required.

A process has been implemented during 2018/19 and will be continued into the forthcoming year for review of compliance with the audit action plans, and these reviews have been included in the annual programme.

For detail of the clinical audit programme activity and delivery for 2018/19, see Clinical Audit section on page QR28 of this report.

Forward Programme 2019/20

At the time of this report being prepared the annual audit programme for 2019/20 has 71 projects/ topic areas for clinical audits to be undertaken against. The projects/audit topics vary in the audit reports they generate; ranging from none e.g. National audit reports generated by the National audit team to multiple reports e.g. a report to each Care Group of a Trust wide audit.

An internal review of the clinical audit programme database has taken place during 2018/19 to produce a forward programme for 2019/20 which:

- Is outcome focused.
- Provides accurate data for clinical audit activity and delivery.
- Allows real time reporting and theme/trend analysis for day to day operational use by the Clinical Audit team.
- Will generate the required reports through the Trust’s Governance structures.
- Provides assurance on the audit process, including activity and actions taken against the overall audit outcome rating for the audit.

Clinical Policies

During 2018/19 a comprehensive internal review of the process for ratification of clinical policies has taken place. Steps have been taken to implement a robust framework and provide Trust Board (via Quality Committee) with assurance that:

- The ratification of all clinical polices is 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.

This includes:
• A monthly ‘Clinical Policies Review and Approvals Group’ (CPRAG) whose terms of reference of the group contributes to the delivery of the Strategic Ambitions (and Quality Priorities) of the Trust.

• 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 that it is 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.

National Institute for Health and Clinical Excellence (NICE)

The role of NICE is to improve outcomes for people using the NHS and other public health and social care services by:

• Producing evidence-based guidance and advice for health, public health and social care practitioners.

• Developing quality standards and performance metrics for those providing and commissioning health, public health and social care services.

• Providing a range of information services for commissioners, practitioners and managers across the spectrum of health and social care.

Rotherham Doncaster and South Humber NHS Foundation Trust utilises a NICE ‘Health Assure’ database which uploads NICE guidance throughout the month. Currently there are nine identified NICE leads across the Trust who can access this database and provide assurance of compliance where NICE guides are relevant, and to upload evidence to support this.

The Trust now accesses all NICE guides (including Quality Standards) on one view page. NICE quality standards set out what a quality service should look like and the Trust aims to achieve this ‘best practice’ level, to support its assurance to deliver the best care possible.

In 2018/19 NICE published 157 guidance documents (including Quality Standards; of which 48 were determined to be relevant to the Trust from April 2018 to February 2019, and of seven guides so far published for March 2019 it is estimated that three will be relevant. Relevance varies from awareness to fully compliant. NICE Guidelines may be re-reviewed and updated at any point following their initial release.

Examples include:

• **NG100 (Updated July 2018) Rheumatoid arthritis in adults: management** - The guideline covers diagnosing and managing rheumatoid arthritis. It aims to improve quality of life by ensuring that people with rheumatoid arthritis have the right treatment to slow the progression of their condition and control their symptoms. People should also have rapid access to specialist care if their condition suddenly worsens. Adult Community Nursing Service to update.

• **NG88 - (Updated Nov 2018) Heavy menstrual bleeding: assessment and management** This guideline covers assessing and managing heavy menstrual bleeding (menorrhagia). It aims to help healthcare professionals investigate the cause of heavy periods that are affecting a woman's quality of life and to offer the right treatments, taking into account the woman's priorities and preferences.

• **QS171 Medicines management for people receiving social care in the community** This quality standard covers assessing if people need help with their medicines and deciding what medicines support is needed to enable people to manage their medicines. It also includes communication between health and social care staff to ensure people have the medicines support they need.
NICE quality standards

NICE Quality standards set out what a quality service should achieve and whilst not mandatory may be considered best practice. The Trust uses NICE quality standards to support service development/improvements for patients and to assure they deliver the best care possible.

The Trust reviews NICE Quality Standards alongside all other NICE guides with a view to implementing as required where applicable. Guidance may be sought from the Trust’s commissioners where it is deemed current arrangements do not support the Quality Standard.

NICE consultations

The Trust considers all notified NICE consultations and where appropriate will register as a stakeholder. Involvement in identified consultations supports the development of guidance and quality standards.

During 2018/19, the Trust contributed as a stakeholder, to the following NICE consultations registered by the Clinical Effectiveness Lead. Individual staff members may also register as stakeholders in their own right; however registrations are limited to a maximum of two per health provider:

- Rehabilitation in people with severe and enduring mental illness.
- Suicide Prevention.
- Management of fever in under five-years-olds

3.3 Patient Experience

RDaSH recognise the importance of implementing and maintaining effective patient engagement and appreciates that patient experience is vital to underpinning the organisations reputation and performance. Effective Patient Engagement and Experience (PPEE) arrangements aim to provide high satisfaction outcomes for service users, their families and carers, promoting their health and quality of life.

The PPEE Strategy 2016 -2019 is in its second year and continues to be implemented and embedded throughout the four Care Groups and the actions of the following nine themes are reviewed on a quarterly basis via the Listen to Learn Co-Production Network and exception reported in a six monthly assurance statement and annual report.

- Involving patients and carers to recruit staff.
- Working with patients and carers to train staff.
- Developing peer support.
- Involving Members and Governors.
- Promoting volunteering opportunities.
- Supporting experts by experience.
- Encouraging co-design.
- Making feedback meaningful.
- Promoting recovery-focused delivery of service.

The forward plan for the forthcoming year (2019/20) is to:

- Continuously improve participation and incorporate learning and best practice across the Trust.
- Implement and embed year three of the strategy, building on the achievements of the Listen to Learn and Carer Champion networks.
• Increase participation and engagement across all our localities, encouraging service users, friends, family and carers and members of the public to communicate and network with staff and senior managers to co-produce and deliver safe effective care.

Capturing Feedback

In order to improve the quality of services that RDaSH provides, it is important that we understand what people think about the care and treatment they receive. One way of doing this is to ask people who have recently used our services to tell us about their experiences. Capturing patient/carer feedback is one of the priorities of the PPEE strategy and we currently use a variety of methods both formal and informal including the following:

• Your Opinion Counts.
• Compliments.
• Complaints.
• Patient Advice and Liaison Service (PALS).
• Friends and Family Test.
• Patient Opinion/NHS Choices.
• Patient Stories.
• Listening into Action Big Conversation events.
• Listen to Learn Co-production Network.
• Triangle of Care Steering Group.
• Trust public meetings.
• Trust Member’s and Governor meetings.
• Local Healthwatch Feedback Centers.
• Local partner public meetings.
• Representation on partnership engagement meetings/forums.

Community Mental Health Survey

The Trust participated in the Community Mental Health Survey 2018 which is part of a series of annual surveys required by the Care Quality Commission for all NHS Trusts who provide mental health care in England.

The content of the Mental Health Community Service User Survey is determined nationally as is the covering letter. The questionnaire and letter were sent out on behalf of RDaSH by Quality Health who is our approved contractors.

The survey was undertaken by Quality Health between February and June 2018 and is a randomised sample of all service users aged 18 years and over who were on the RDaSH Care Programme Approach (CPA) and non CPA register between 1 September and 30 November 2017. 806 service users were contacted by post and a total of 220 completed surveys were returned 27%, which is the same percentage response as in 2017.

The report is presented in a way that allows organisations to view their own specific data for the past three years and benchmark themselves with other Quality Health clients who participated in the survey.

The overall results for the Trust presents a positive picture and many of the scores are in the top 20% of all Trusts surveyed by Quality Health. The remaining scores are in the intermediate range, no scores are in the lower 20% range. Although the majority of the results in 2018 are higher than the national range, there is a slight downward trend in both RDaSH and national figures.
The full outcomes of the RDaSH survey are broken down into ten specific categories and one overall category. There are 13 recommendations which is an improvement on the 2017 survey which had 19 recommendations.

Each care group has its own action plan relating to the recommendations which are reviewed via the Care Group Quality and Governance meetings and are exception reported to the overarching Organisational Management Meeting.

<table>
<thead>
<tr>
<th>Table 16: Community Mental Health Survey Comparative Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Scores</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>RDaSH</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
</tr>
<tr>
<td>In the last 12 months did you have a very good experience?</td>
</tr>
<tr>
<td>71.8% 69.8% 72.2% 70.3 70.4 68.4</td>
</tr>
<tr>
<td>In the last 12 months did you feel you were treated with respect and dignity by NHS Mental Health Services?</td>
</tr>
<tr>
<td>87.1 83.4 86.4 83.3 82.6 82.9</td>
</tr>
</tbody>
</table>

The comparative data displayed in this report is from 53 Mental Health Trusts and Community Interest Companies with mental health functions surveyed by Quality Health this year (95% of the total number of surveyed organisations).

Complaints and compliments

When people access our services, most care and treatment goes well, but things occasionally do go wrong. Rotherham Doncaster and South Humber NHS Foundation Trust have a complaints policy which provides a framework to:

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

The main categories of complaints received within the Trust in 2018/19 relate to:

- Patient Care.
- Clinical treatment.
- Communications.
- Values and Behaviours of Staff.

Table 17 shows the number of complaints across the Trust in comparison to the previous four years and an increase in the number reported year on year since 2016/17. This is viewed by the Trust as a positive reinforcement of an open and transparent culture; that encourages reporting of complaints to inform and influence improvements in quality and service delivery.

<table>
<thead>
<tr>
<th>Table 17: Complaints and compliments across the Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Complaints</td>
</tr>
<tr>
<td>137 165 119</td>
</tr>
<tr>
<td>Compliments</td>
</tr>
<tr>
<td>1166 1222 882</td>
</tr>
</tbody>
</table>

Source: Ulysses Incident Reporting System
Patients and service users may also want to contribute positive comments on the care and services that they have received. These comments are just as important because they tell us which factors are contributing to a good experience for patients. Table 18 also shows the number of compliments that have been received in 2018/19.

Feedback received through the Trust’s Patient Safety and Investigations Team is shared with the relevant care groups, to both disseminate the positive comments that have been received and to develop action plans to address areas of concern.

**Your Opinion Counts / Patient Advice Liaison Service**

‘Your Opinion Counts’ (YOCs) and the Patient Advice Liaison Service (PALS) provide patients, service users and carers with alternative methods of providing feedback to the Trust. Table 18 shows the number of PALS and YOC received in 2018/19.

| Table 18: Patient feedback received via PALS and local Your Opinion Counts |
|---------------------------------|-----------------|-----------------|-----------------|
| Indicator                       | 2016/17         | 2017/18         | 2018/19         |
| Patient Advice Liaison Service  | 425             | 337             | 433             |
| Your Opinion Counts             | 3128            | 2730            | 2707            |

*Source: Ulysses, Trust reporting system and local reporting system*

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

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

**Eliminating mixed sex accommodation (EMSA)**

Providers of NHS funded care are asked to confirm whether they are compliant with the national definition “to eliminate mixed sex accommodation except where it is the overall best interests of the patient, or reflects their patient choice”. The Trust’s EMSA declaration April 2018 can be found on [http://www.rdash.nhs.uk/about-us/public-declarations/delivering-same-sex-accommodation](http://www.rdash.nhs.uk/about-us/public-declarations/delivering-same-sex-accommodation). The Trust has an excellent record in eliminating mixed sex accommodation, with the majority of inpatient care being provided on wards that have single ensuite bedrooms. For those wards that do not have ensuite facilities clear guidance is provided for the care of patients to ensure that no breach occurs and also to maintain all patients privacy and dignity. All mental health and learning disability wards also have ladies only lounges.

Eliminating mixed sex accommodation is only part of the patients experience with regard to maintaining their privacy and dignity and therefore there is an on-going work programme in place with all inpatient modern matrons. This work continually updates approaches and ensures the Trust maintains the high profile that dignity within care should have.

**Breaches in providing same sex accommodation**

There have been 0 reported breaches in EMSA during 2018/19.
Patient-Led Assessments of the Care Environment (PLACE)

The 2018 Patient Led Assessments of the Care Environment (PLACE) were undertaken between March and April 2018.

The PLACE assessments were led by trained ‘Patient Assessors’ and included Governors, Health Watch (Doncaster and Scunthorpe), Volunteers, and in-patients, and were facilitated by trained staff assessors from Facilities, Human Resources, Corporate Services, and the Infection Prevention and Control Team.

The 2018 assessments focused on six key themes:

- Cleanliness.
- Food.
- Privacy and Dignity.
- Condition and Appearance.
- Dementia.
- Disability.

The Trust results from the 2018 survey show that the Trust is above the national average for all areas with the exception of ‘cleanliness’ which is slightly below the national average. This is detailed in Table 19 below.

<table>
<thead>
<tr>
<th></th>
<th>Cleanliness</th>
<th>Food and Hydration</th>
<th>Privacy and Dignity</th>
<th>Condition / Appearance</th>
<th>Dementia</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>RDaSH average 2018</td>
<td>98.26%</td>
<td>92.61%</td>
<td>90.93%</td>
<td>96.86%</td>
<td>91.57%</td>
<td>89.59%</td>
</tr>
<tr>
<td>National Average 2018</td>
<td>98.5%</td>
<td>90.2%</td>
<td>84.2%</td>
<td>94.3%</td>
<td>78.9%</td>
<td>84.2%</td>
</tr>
<tr>
<td>Variation</td>
<td>-0.24%</td>
<td>+2.41%</td>
<td>+6.73%</td>
<td>+2.56%</td>
<td>+12.67%</td>
<td>+5.39%</td>
</tr>
</tbody>
</table>

There has been an overall improvement in the 2018 results for the Trust when compared to 2017 in the areas of ‘food and hydration’, ‘dementia’ and ‘disability’, see Table 20 below.

<table>
<thead>
<tr>
<th></th>
<th>Cleanliness</th>
<th>Food and Hydration</th>
<th>Privacy and Dignity</th>
<th>Condition / Appearance</th>
<th>Dementia</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>RDaSH average 2017</td>
<td>98.5%</td>
<td>88.6%</td>
<td>93.3%</td>
<td>97.3%</td>
<td>79.9%</td>
<td>88.4%</td>
</tr>
<tr>
<td>RDaSH Average 2018</td>
<td>98.26%</td>
<td>92.61%</td>
<td>90.93%</td>
<td>96.86%</td>
<td>91.57%</td>
<td>89.59%</td>
</tr>
<tr>
<td>Variation</td>
<td>-0.24%</td>
<td>+4.01%</td>
<td>-2.37%</td>
<td>-0.44%</td>
<td>+11.67%</td>
<td>+1.19%</td>
</tr>
</tbody>
</table>

A comparison of Trust results on a site by site basis of the 2017 and 2018 results is shown in Table 21 below.
Table 21: RDaSH comparison of site results 2017 versus 2018

<table>
<thead>
<tr>
<th>Site</th>
<th>Cleanliness</th>
<th>Food and Hydration</th>
<th>Privacy and Dignity</th>
<th>Condition / Appearance</th>
<th>Dementia</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tickhill Road Site</td>
<td>97.78%</td>
<td>98.80%</td>
<td>88.65%</td>
<td>93.67%</td>
<td>90.50%</td>
<td>87.50%</td>
</tr>
<tr>
<td>Woodlands</td>
<td>98.86%</td>
<td>98.83%</td>
<td>88.22%</td>
<td>93.67%</td>
<td>90.50%</td>
<td>87.50%</td>
</tr>
<tr>
<td>Emerald</td>
<td>97.62%</td>
<td>97.92%</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>96.43%</td>
</tr>
<tr>
<td>Great Oaks</td>
<td>97.32%</td>
<td>97.48%</td>
<td>84.10%</td>
<td>91.21%</td>
<td>84.88%</td>
<td>96.34%</td>
</tr>
<tr>
<td>Swallownest</td>
<td>98.73%</td>
<td>96.45%</td>
<td>87.75%</td>
<td>91.50%</td>
<td>95.91%</td>
<td>91.53%</td>
</tr>
<tr>
<td>St John’s Hospice</td>
<td>99.67%</td>
<td>97.39%</td>
<td>94.27%</td>
<td>97.08%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>New Beginnings</td>
<td>99.65%</td>
<td>99.33%</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>93.33%</td>
</tr>
</tbody>
</table>

An action plan has been developed as a result of the PLACE survey and covers the period 2018/19. This is detailed in Table 22 below.

Table 22: PLACE action plan 2018/19

<table>
<thead>
<tr>
<th>No.</th>
<th>Patient led assessment of the care environment criteria</th>
<th>Planned action inc. resources to meet criteria</th>
<th>By when</th>
<th>Progress as at 23/08/2018</th>
<th>Action completed and confirmed by</th>
<th>Sustainability</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Internal decoration should be bright, coordinated and in good condition. Paintwork should be free from chips, scratches and other damage.</td>
<td>1) A planned programme for the redecoration of Amber Lodge. 2) A planned programme for the redecoration of Jubilee 1.</td>
<td>31/12/18</td>
<td>31/3/19</td>
<td>1) Redecoration on Amber Lodge has commenced. 2) Planned to commence late 2018.</td>
<td>To be confirmed at Care Group Quality and Standards (Q and S) meeting. Part of ongoing Trust wide redecoration programme.</td>
</tr>
<tr>
<td>2</td>
<td>Waste bins should have ‘no touch’ or foot operated and ‘silent closing’ mechanisms, which should be working. (Silent closing is not necessary in single rooms or non-bedded areas).</td>
<td>When replacing waste bins on the wards, ensure they have silent closing mechanisms.</td>
<td>Ongoing</td>
<td>Information passed on to the purchasing departments ‘buying team’ to police orders which are placed.</td>
<td>To be confirmed at Care Group Q and S meeting. Ongoing replacement programme as orders are made by wards.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Availability of hot and cold meal choices for both lunch and evening meal.</td>
<td>Review of patient meal to ensure a selection of hot and cold meal choices are available at both meal sittings.</td>
<td>31/12/18</td>
<td>Menu review group established in May 2018. Patient engagement with Great Oaks in-patients. Week one draft menu complete.</td>
<td>To be confirmed at Care Group Q and S meeting. Continue to respond to patient feedback.</td>
<td></td>
</tr>
</tbody>
</table>
3.4 Our People/Staff

Staff views of quality

Staff are vital to the delivery of high quality, safe and clinically effective care. The views of our staff on their ability to deliver high quality care are important in helping us shape our plans for quality improvement. Tables 23 and 24 show our performance against key measures and indicators over previous years.

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

- Surveys.
- “Big Conversation” workshops.
- Chief Executive blog.
- Professional networks.
- Trust Matters.

Staff survey

<table>
<thead>
<tr>
<th>Staff Survey Questions</th>
<th>2017 RDaSH % strongly agree or agree</th>
<th>2018 RDaSH % strongly agree or agree</th>
<th>2018 average for other MH trusts % strongly agree or agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust</td>
<td>62%</td>
<td>67%</td>
<td>66%</td>
</tr>
<tr>
<td>I am satisfied with the quality of care I give to patients/service users.</td>
<td>81%</td>
<td>85%</td>
<td>80%</td>
</tr>
<tr>
<td>I feel that my role makes a difference to patients/service users.</td>
<td>87%</td>
<td>87%</td>
<td>88%</td>
</tr>
<tr>
<td>I am able to deliver the patient care I aspire to.</td>
<td>67%</td>
<td>71%</td>
<td>66%</td>
</tr>
<tr>
<td>I am able to make improvements happen in my area of work.</td>
<td>54%</td>
<td>54%</td>
<td>58%</td>
</tr>
</tbody>
</table>

Source: CQC
### Table 24: Staff survey results for KF21 and KF26

<table>
<thead>
<tr>
<th>Staff Survey Questions</th>
<th>2017 RDaSH</th>
<th>2018 RDaSH</th>
<th>2018 average for other MH trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff believing that the organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age.</td>
<td>88%</td>
<td>90%</td>
<td>86%</td>
</tr>
<tr>
<td>Percentage of staff experiencing harassment, bullying or abuse at work from managers in the last 12 months (Q13b).</td>
<td>8%</td>
<td>9%</td>
<td>11%</td>
</tr>
<tr>
<td>Percentage of staff experiencing harassment, bullying or abuse at work from other colleagues in the last 12 months (Q13c).</td>
<td>12%</td>
<td>12%</td>
<td>16%</td>
</tr>
</tbody>
</table>

Source: CQC

### 3.5 Performance Against Mandated National Indicator Measures and Performance Thresholds

Monitor set targets for Foundation Trusts as part of its ‘Risk Assessment Framework’ and part of appendices one and three of the ‘Single Oversight Framework’. Table 25 shows our progress against the Mental Health and Learning Disability governance indicators for 2018/19 and where applicable includes comparative information for the two previous years.

### Table 25: Performance against Monitor’s mental health governance indicators

<table>
<thead>
<tr>
<th>Targets</th>
<th>Threshold</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early intervention in Psychosis (EIP): People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral. ^</td>
<td>53%</td>
<td>91%</td>
<td>93%</td>
</tr>
<tr>
<td>Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) Inpatient wards.</td>
<td>90%</td>
<td>100%</td>
<td>94%</td>
</tr>
<tr>
<td>b) Early Intervention in Psychosis Services.</td>
<td>90%</td>
<td>95%</td>
<td>93%</td>
</tr>
<tr>
<td>c) Community Mental Health Services (people of care programme approach).</td>
<td>65%</td>
<td>82%</td>
<td>88%</td>
</tr>
<tr>
<td>Improving Access to Psychological Therapies (IAPT): a) Proportion of people completing treatment who move from recovery (IAPT dataset).</td>
<td>50%</td>
<td>53%</td>
<td>56%</td>
</tr>
<tr>
<td>b) Waiting time to begin treatment (from IAPT minimum dataset) within six weeks of referral.</td>
<td>75%</td>
<td>89%</td>
<td>85%</td>
</tr>
<tr>
<td>c) Waiting to begin treatment (from IAPT minimum dataset) within 18 weeks of referral.</td>
<td>95%</td>
<td>100%</td>
<td>99%</td>
</tr>
<tr>
<td>Care programme approach follow up: Proportion of discharges from hospital followed up within seven days.</td>
<td>See Table 8 (page QR33)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admissions to adult facilities of patients under 16 years old.</td>
<td>n/a</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Inappropriate out-of-area bed days for adult mental health services (average per month)^.</td>
<td>&lt;110</td>
<td>148</td>
<td>87</td>
</tr>
</tbody>
</table>

Source: RDaSH performance reports

^ Marker of specific indicators which have been audited by the Trust’s External Auditors. The external auditors report (Annex 4) has highlighted improvement areas in respect of these two metrics and the Trust has agreed actions to be taken to strengthen the associated input, collation and reporting processes.
Annexes

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

NHS Rotherham Clinical Commissioning Group (CCG)

The Commissioner welcomes this opportunity to provide feedback to the Rotherham Doncaster and South Humber NHS Foundation Trust’s document ‘Quality Report 2018/19’ and ‘Forward Strategy 2019/20’. The RCCG is particularly keen to highlight the achievements of RDaSH in relation to a number of areas which are detailed below.

I welcome the RDaSH Annual Quality Report. As mental well-being is now recognised as increasingly important to the health of the nation, so is the requirement for excellent mental health services. Once again there is clear evidence of the commitment all those involved to improve these services for the people of Rotherham. From CAMHS for children and young people through working age adults and into the elderly mental health services RDaSH provide an extensive range of person-centred care. Rotherham CCG is pleased to have been able, with an increase in funding, to work closely with RDaSH to achieve improved outcomes for all those who access their services. Of especial note this year has been the work on supporting survivors of CSE, those suffering from eating disorders and IAPT.

Suicide rates and waiting times for ASD/ADHD diagnosis remain troubling and much work has been done between commissioners, RDaSH and local public health colleagues in these priority areas.

Dr Russell Brynes
Mental Health GP Lead
5 May 2019
Doncaster Clinical Commissioning Group (CCG) is pleased to comment on the Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) Annual Quality Report 2018/19 and Forward Strategy 2019/2020. Partnership working with our local Trusts ensures a robust joint approach to the commissioning and delivery of care to Mental Health Learning Disabilities and Community patients in Doncaster. We continue to work together to ensure the best quality and evidence based care is available to all.

2018/19 has been a year of significant progress which saw the development of RDASH’s Five Year Strategy 2019-2024 titled after their strategic vision ‘Leading The Way With Care.’

The report provides both a retrospective view of the Trust’s key quality improvement achievements and challenges they faced. It also sets out the key quality proprieties for the coming year keeping a balanced view of the three domains of quality:

- Patient Safety.
- Clinical Effectiveness.
- Patient Experience.

In February 2018 the Trust were visited by the CQC who conducted a ‘well led inspection of their core services. The trust achieved an overall rating of ‘Good’ which was maintenance from their last rating.

The Trust continues to demonstrate an open and honest culture. As such they have developed a Board Assurance Framework (BAF) which has identified strategic risks that may impact on the achievement of its strategic goals. Their quality proprieties are linked to the risks identified and acts as a control to prevent the risk occurring. The progress and achievement of the quality priorities provide assurance on the mitigation of the risks which are reviewed on a regular basis. A summary board report is provided on a monthly basis to the CCGs Clinical Quality Review Group (CQRG).

Patient safety continues to be a key priority. Learning from incidents is reported through the Trust’s quality governance structures to drive quality, standards and service improvements. The CCG is pleased to see a key priority for 2019/20 which is to continue to implement robust systems and processes to enable shared organisational leaning from reported incidents across their Trust.

The Trust’s annual audit programme has been actively delivered incorporating audits nationally, locally and to enable measurement against the national CQUIN scheme. An internal review of their audit database has enabled the trust to produce a forward programme which is outcome focussed, this in turn will generate reports through the Trust’s governance structures which will provide assurance on the audit process and actions taken against the outcomes.

An emphasis on patients and their experience continues to be a key driver ensuring participation and leaning from patient feedback is incorporated into best practice across the Trust and its services.

Through 2018/19, the Trust made significant progress and achieved most of the outcomes identified through the CQUIN scheme for both mental health services and community based nursing services. The trust as part of the scheme undertook local initiatives to ensure they were active partners of the Integrated Care System and place plan. The Trust have agreed ambitious National CQUIN schemes for the coming year that sit alongside and complement the ‘Ten Year Plan’.

The CCG look forward to working with the Trust as they continue with their priorities for improvement in 2019/20 which cover six ambitions which prove the building blocks on which to provide high quality care, deliver excellence, drive innovation and deliver best practice outcomes for patients.

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

Andrew Russell
Chief Nurse, NHS Doncaster Clinical Commissioning Group
1 May 2019
The CCG is pleased to see that Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) retained the CQC rating of Good following the latest Well-Led inspection of the Trust’s core services undertaken in 2018. This is a significant achievement and North Lincolnshire Clinical Commissioning Group (CCG) recognises the progress made by the Trust to achieve this outcome. The CCG will continue to support the Trust to maintain a continued focus on their improvement journey during 2019/20 to ensure that this position is sustained.

The CCG wish to note other improvements that have been achieved during the year including compliance with CQUIN indicators; improvement in the standard of quality and performance information provided to the CCG; improved collaboration with the CCG in relation to the management of incidents and serious incidents; and reduction in the use of restrictive interventions through the use of Positive Behavioural Support Plans.

While the CCG acknowledge the progress and improvement made by the Trust against the quality priorities for 2018/19, there remain some areas that are not meeting the required standards and where further improvement is needed including:

- The response provided by the Trust in the local adult Crisis Service for patients experiencing an acute mental health crisis; and,
- Waiting times in the Child and Adolescent Mental Health Services (CAMHS) Getting Advice (ASD) service in North Lincolnshire.

The CCG is working closely with the Trust to review demand for these services against capacity to ensure that the services are able to meet the patients’ needs.

Other areas that require further improvement in 2019/20 in order to achieve national and local quality standards include:

- The timeframe for responding to complaints.
- The response rate to the Friends and Family Test.
- Compliance with Safeguarding Adults Training (level 2).
- Compliance with Safeguarding Children training (level 3).
- Compliance with Domestic Abuse training (Level 2).

The Trust’s quality priorities for 2019/20 are welcomed by the CCG. We recognise the these priorities have the potential to improve the safety, effectiveness and experience of services provided by the Trust in North Lincolnshire.

Chloe Nicholson  
Head of Quality  
NHS North Lincolnshire CCG  
9 May 2019
Healthwatch Rotherham

Healthwatch Rotherham continues to have an excellent co-operative working relationship with Rotherham Doncaster and South Humber NHS Foundation Trust.

Healthwatch Rotherham attend Listen to Learn Network events where patients, carers and service users come together for a quarterly update and to get involved in the delivery of the Patient and Public Engagement and Experience Strategy.

We pass on the data we receive about RDaSH via our Feedback Centre and our NHS Complaints Advocacy Service to help The Foundation Trust to gain a wider view of the public’s opinion. These comments have helped to inform the Trust’s Quality Accounts and focus on areas of improvement for the next year. It is good to see patient experience at the top of the improvement priorities, assessment and communication are two areas regularly raised. We welcome the Trust’s commitment to improving the patients experience by investing in additional training.

Healthwatch Rotherham produced a review of Rotherham CAMHS during September 2018, producing a report which was presented to the Trust, Rotherham CCG and Rotherham Health and Wellbeing Board to ensure that the families have their voice heard at every level.

Healthwatch Rotherham looks forward to continuing to grow and develop our good working relationship with all at Rotherham Doncaster and South Humber NHS Foundation Trust.

Tony Clabby  
Chief Executive Officer  
Healthwatch Rotherham  
13 May 2019

Healthwatch Doncaster

Healthwatch Doncaster is pleased to provide comments and a response to Rotherham, Doncaster and South Humber NHS Foundation Trust’s (RDaSH) 2018-19 Quality Accounts.

Healthwatch Doncaster recognises the value that RDaSH places on capturing the experience of feedback of people who use its services.

Healthwatch Doncaster has attended and been involved in the Listen to Learn Network and receives regular information updates that are shared across our groups, networks and membership.

Healthwatch Doncaster attended the Recovery Games in 2018 that was organised and delivered by Aspire. This was a fantastic event and Healthwatch Doncaster used it as opportunity to gather views from attendees about their use of urgent and emergency care services as part of System Perfect Week.

Healthwatch Doncaster recognises that there is more joined up work linked to patient and service user voice that could be actioned by both Healthwatch Doncaster and RDaSH.

Andrew D. Goodall  
Chief Operating Officer  
Healthwatch Doncaster  
9 May 2019
Healthwatch North Lincolnshire welcomes the opportunity to make a statement on the Quality Account for Rotherham, Doncaster and South Humber NHS Foundation Trust. We recognise 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 following is the response from Healthwatch North Lincolnshire.

It is clear from the quality account that the trust are keen listen to and engage with staff, patients and their carers to ensure the highest quality of care for those who use the services. The introduction of the Carers’ Charter is a positive step as it recognises the vital role of carers and friends in the treatment and recovery of the patient.

This Quality Account clearly illustrates aspects of the Trust's performance during 2018/19. The detail is intended to be informative to both professionals and the public.

However it should be noted that phrases such as ‘relevant health services’ and abbreviations are not easy to understand by the general public and development of an ‘easy read’ version, with a glossary of terms would be useful.

It is difficult to comment on progress against some of the targets, without clear explanation of what each one means. It would be beneficial for Healthwatch to be involved at an earlier stage for future Quality Accounts, to ensure that an explanation of each metric is given.

Overall it would appear that 2018/19 has been a positive year for the Trust and robust measures have been implemented to secure future improvement.

Healthwatch applauds efforts of all staff to improve mental health services offered to those that live within North Lincolnshire. We look forward to seeing the ambitions in the five year strategy developing in future quality accounts.

Carrie Butler
Delivery Manager
Healthwatch North Lincolnshire
8 May 2019
Rotherham Health Select Commission

Response to RDaSH Quality Report 2018-19

The RDaSH sub-group from the Health Select Commission (HSC) have considered the draft Quality Report and also met twice during 2018-19 to discuss progress on both the quality priorities and on the actions taken by the Trust since the CQC inspection. There has also been a focus on the Rotherham Quality Dashboard for Patient Safety and harm free care. Members value being presented with this information and having the opportunity to ask questions regarding challenges, performance and delivering further quality improvements.

The Commission welcomed the progress made on the quality priorities during the year and expects this to continue in 2019-20 under the new overarching five year strategy “Leading the Way with Care”. In particular good performance on working with carers, the staff survey results on quality, mandated national performance indicators and the PLACE assessments regarding dementia was acknowledged.

The development of the Trust’s own electronic patient record system, coupled with the Rotherham Health Record, will help to support safe and integrated care for patients. There is a strong focus across the NHS on use of technology and e-systems which is reflected in RDaSH’s quality objectives for next year and HSC hopes funding is available to develop this fully to bring additional benefits for staff, patients and families/carers.

Members are supportive of the new Integrated Performance Dashboard and intention to strengthen the governance structure to link quality, performance and assurance at all levels.

Although the overall CQC rating for RDaSH is “Good” HSC expects to see that the actions taken will result in an improvement in those CQC ratings that were “Requires Improvement”, and especially overall for the Safety domain, this year.

Members recognise the workforce recruitment challenges, especially for qualified nurses, and acknowledge the initiatives taken to be proactive on this issue to ensure the right skills mix, safe staffing levels and to provide support for staff working for the Trust.

As Chair I recognise that mandatory and statutory training (MAST) compliance is an issue for many trusts and it is very positive that RDaSH has achieved its 90% stretch target. Better capture of data on staff participation in training and assurance that people have had training at the right level for their role is an important issue, especially with regard to safeguarding. I would expect the Trust to continue to focus on this.

The Health Select Commission appreciates the willingness of the Trust to engage regularly with Members, by attending meetings and providing information, as well as taking on board their comments and concerns. HSC expects this to continue and looks forward to working closely with the Trust again in 2019-20 when scrutiny of mental health services across all ages, developments in delivery of integrated care, and the estates strategy will again feature in the work programme.

Cllr Simon Evans
Chair, Health Select Commission
8 May 2019
Doncaster Health and Adult Social Care Scrutiny Panel

The Annual Report was circulated to the member Councillors of the Health and Adult Social Care Scrutiny Panel and no comments were made.

Christine Rothwell
Senior Governance Officer,
Doncaster Metropolitan Borough Council
2 May 2019

North Lincolnshire Council Health Scrutiny Panel

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

The panel notes the Trust’s generally encouraging performance metrics against its agreed priorities. In particular, the panel is pleased to see continued improvements on the provision of safe, effective care and on providing ‘listening’ services. The panel also notes the 2018 CQC report on the Trust’s work, and would wish to praise all services that improved throughout the year, and in particular, those rates as outstanding. Despite this, we note that further work is required on some core indicators described in section 2.3.

The panel welcomes the future strategic ambitions outlined and agreed by the Trust, in particular continued efforts to holistically integrate physical and mental health care. For many years, the panel has advocated such an approach so we are encouraged that the Trust intends to achieve parity of esteem, particularly for children and young people.

On work-related issues, Trust representatives have been very open to work with the panel throughout the year, most notably on ongoing work to improve the mental wellbeing of children and young people in North Lincolnshire. We believe that this is clear evidence that the Trust has a genuine desire to improve services through working more co-operatively with partners. Finally, any day-to-day queries have always resulted in a swift and comprehensive response, and we thank the Trust for this.

Dean Gillon
Senior Democratic Services Officer
North Lincolnshire Council
Rotherham Doncaster and South Humber NHS Foundation Trust
Council of Governors

The Council of Governors is pleased to have the opportunity to comment on the Quality Report for 2018/2019. Throughout the year Governors have taken opportunities to be closely involved with initiatives to promote and assure quality services within the Trust and brief details are included below:

- The Council of Governors receives a comprehensive performance report at each of its quarterly meetings which includes a section relating to quality – this includes a range of data about the quality of the services provided. This section is presented to the Council of Governors by the Chair of the Quality Committee (Alison Pearson, 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.

- Governors have discussed the Annual (Operational) Plan and the Trust’s Forward Strategy that both make reference to quality priorities and have during the year, received updates from the Chief Executive relating to the external environment and the changes relating to Accountable Care Systems / Integrated Care Systems in which the Trust operates. Two RDaSH Governors take an active part in “The Citizens Panel” element of the South Yorkshire and Bassetlaw Integrated Care System.

- Governors frequently attend the Board of Directors’ meetings and have engaged by asking questions relating to quality matters.

- There are Governor Representatives on the teams that complete the annual Patient-Led Assessment of the Care Environment (PLACE) visits

- Governors have attended a number of groups and events which are focused on ways to involve service users, carers and stakeholders in how the Trust delivers its services – these are listed below. Where Governors cannot attend, the reports to the Council of Governors include details of the group or event to ensure all Governors are aware of these activities and those that have attended are invited to provide their feedback to their fellow Governors.
  - Frequent attendance at the Listen to Learn Network and Carer Champion Network events.
  - Representation on the Triangle of Care Steering Group.
  - Governors have attended and made useful contribution to the Listening into Action workshops where they engage with staff members to listen to their experiences and opinions.
  - Visits to service user/patient and carer user groups and other community events.
  - Visits to services and Service Focus Groups.
  - Governors have proactively engaged with the wider public, recruiting new foundation trust members and volunteers for the Trust.
  - Governors have held ‘members’ drop-in’ events in Rotherham and Doncaster to engage with their members and to look for opportunities to recruit new members – This includes a ‘membership roadshow’ each year during the Trust's Membership Week.
  - Equality Diversity and Human Rights Steering Group (and to continue this attendance in care group meetings).
  - Active engagement as “Patient Research Ambassadors” for RDaSH.

Governors have attended and participated in a number and range of more formal / corporate events including:

- Annual Members’ Meeting.
- Public Board of Directors’ meetings.
- Charitable Funds Committee.
• Audit Committee.
• Medicines Management Committee.
• Other corporate events at the Trust including the Graduation Ceremony, official openings, Volunteers’ festive lunch and the Annual Awards Ceremony (with Governors represented as judges on the Awards).

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

• Governor and ‘agenda-less' constituency meetings with the Chair.
• Election information events to promote the role of Governor and recruit new members.
• 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. During the year this has also included Governors participating in the recruitment process for the Director of Nursing and AHPs.
• The Governors have, during the year had access to the full range of training provided by NHS Providers (Governwell) and a bespoke training event hosted by the Trust that have all contributed to a better understanding of the role and responsibilities. Governors have also accessed Mental Health First Aid Training from the Trust.
• The Council of Governors selected the local indicator for external audit (data quality) testing this year as Care Programme Approach (CPA) seven day follow up indicator.

The Council of Governors support the content of the report as an open and honest reflection of the Trust’s position. The Council of Governors will work closely with the Board of Directors, staff, service users, carers and public over the coming year to achieve the quality priorities contained within the Quality Forward Strategy 2018/19.

The Council of Governors are pleased to have had the opportunity to review and discuss the draft Quality Report and to provide suggested changes that have been made. The Council of Governors recommend that this and all reports from the Trust are clear not only about the action being taken but also the associated timescales and the assurance that changes made have been embedded in practice.

The Council of Governors welcomes continuing developments among Governors, 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.

Presented to and approved by the Council of Governors 16 May 2019
Annex 2: Statement of directors’ responsibilities for the quality report

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

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

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

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 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 2018 to 24 May 2019.
  - Papers relating to quality reported to the board over the period April 2018 to 24 May 2019.
  - Feedback from commissioners:
    - Rotherham Clinical Commissioning Group. 7 May 2019
    - Doncaster Clinical Commissioning Group. 1 May 2019
    - North Lincolnshire Clinical Commissioning Group. 9 May 2019
    - Feedback from governors dated. 16 May 2019
    - Feedback from Rotherham Healthwatch organisation. 13 May 2019
    - Feedback from Doncaster Healthwatch organisation. 9 May 2019
    - Feedback from North Lincolnshire Healthwatch organisation. 8 May 2019
  - Feedback from Overview and Scrutiny Committee:
    - Rotherham Health Select Commission. 8 May 2019
    - Doncaster Health Scrutiny Panel. 2 May 2019
    - North Lincolnshire Health Scrutiny Panel. 9 May 2019
  - The Trust's complaints report 2017/18 published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 and the quarterly reports for Q1, Q2, Q3 and Q4 of 2018/19.
  - The latest national community mental health patient survey 2018.
  - The latest national staff survey 2018.
  - The CQC Well Led Inspection report. 28 June 2018
  - The Head of Internal Audit's annual opinion of the Trust’s control environment dated 24 May 2019.
- 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.
- 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

Lawson Pater, Chairman
24 May 2019

Kathryn Singh, Chief Executive
24 May 2019
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.

A Marker of specific indicators which have been audited by the Trust’s External Auditors.

CAMHS: Child and Adolescent Mental Health Service.

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.

LAC: Looked After Children.

Monitor: Independent regulator for foundation trusts.

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.


NRLS: National Reporting and Learning Service.

PLACE: Patient-led assessments of the care environment, which is the new system for assessing the quality of the patient environment.

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.

Human Factors

Human factors examines the relationship between human beings and the systems with which they interact by focusing on improving efficiency, creativity, productivity and job satisfaction, with the goal of minimising errors. A failure to apply human factors principles is a key aspect of most adverse events in health care. Therefore, all healthcare workers need to have a basic understanding of human factors principles.

Three Domains of Quality

Quality within health care can be defined in different ways. The 2008 Darzi NHS Next Stage Review (Department of Health 2008c) defined quality in the NHS in terms of three core areas:

• Patient safety.
• Clinical effectiveness.
• The experience of patients.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

These regulations introduced new fundamental standards, which describe requirements that reflect the recommendations made by Sir Robert Francis following his inquiry into care at Mid Staffordshire NHS Foundation Trust.

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.
Annex 4: Independent auditor’s report to the Council of Governors

Independent auditor’s report to the Council of Governors of Rotherham Doncaster and South Humber NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Rotherham Doncaster and South Humber NHS Foundation Trust to perform an independent assurance engagement in respect of Rotherham Doncaster and South Humber NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'quality report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of Rotherham Doncaster and South Humber NHS Foundation Trust as a body, to assist the Council of Governors in reporting Rotherham Doncaster and South Humber NHS Foundation Trust’s quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Rotherham Doncaster and South Humber NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Early Intervention in Psychosis: people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE) – approved care package within two weeks of referral.
- Inappropriate Out of Area Placements for adult mental health services.

We refer to these national priority indicators collectively as the ‘indicators’.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the ‘NHS foundation trust annual reporting manual’ issued by NHS Improvement.

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

- The Quality Report is not prepared in all material respects in line with the criteria set out in the ‘NHS foundation trust annual reporting manual’ and supporting guidance.
- The Quality Report is not consistent in all material respects with the sources specified in source or list; and
- The indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the ‘NHS Foundation Trust Annual Reporting Manual’ and the six dimensions of data quality set out in the ‘Detailed Guidance For External Assurance on Quality Reports’.

We read the Quality Report and consider whether it addresses the content requirements of the ‘NHS Foundation Trust Annual Reporting Manual’ and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2018 to 24 May 2019.
- Papers relating to quality reported to the board over the period April 2018 to 24 May 2019.
- Feedback from Commissioners:
• Rotherham Clinical Commissioning Group dated 7 May 2019.
• Doncaster Clinical Commissioning Group dated 1 May 2019.
• North Lincolnshire Clinical Commissioning Group dated 9 May 2019.
• Feedback from Governors, dated 16 May 2019.
• Feedback from Rotherham Healthwatch organisation dated 13 May 2019.
• Feedback from Doncaster Healthwatch organisation dated 9 May 2019.
• Feedback from North Lincolnshire Healthwatch organisation dated 8 May 2019.
• Feedback from Overview and Scrutiny Committee:
  • Rotherham Health Select Committee dated 8 May 2019.
  • Doncaster Health Scrutiny Panel dated 2 May 2019.
  • North Lincolnshire Health Scrutiny Panel dated 9 May 2019.
• The Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 and the quarterly reports for Q1, Q2, Q3 and Q4 2018/19.
• The National Community Mental Health Patient Survey 2018.
• The National Staff Survey 2018.
• Care Quality Commission inspection report, dated June 2018.
• The Head of Internal Audit’s annual opinion over the trust’s control environment, dated 24 May 2019.

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

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

**Assurance work performed**

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

• Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.
• Making enquiries of management.
• Testing key management controls.
• Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.
• Comparing the content requirements of the ‘NHS foundation trust annual reporting manual’ to the categories reported in the quality report and
• Reading the documents.

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

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information. The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the ‘NHS foundation trust annual reporting manual’ and supporting guidance.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Rotherham Doncaster and South Humber NHS Foundation Trust.

Basis for qualified conclusion

Early Intervention in Psychosis: people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE) – approved care package within two weeks of referral

The “Early Intervention in Psychosis: people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE) – approved care package within two weeks of referral” indicator requires that the NHS Foundation Trust accurately record the start and end times in accordance with detailed requirements set out in the national guidance. This is calculated as the percentage of adults referred with a first episode of psychosis who receive treatment from early intervention in psychosis services within two weeks of referral.

Our procedures included testing a risk based sample of 25 items, and so the error rates identified from that sample should not be directly extrapolated to the population as a whole.

We identified the following errors:

- In eight cases of our sample of patients’ records tested, the start or end date was not accurately recorded affecting the calculation of the published indicator.

As a result of the issues identified, we have concluded that there are errors in the calculation of the “Early Intervention in Psychosis people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE) – approved care package within two weeks of referral” indicator for the year ended 31 March 2019. We are unable to quantify the effect of these errors on the reported indicator.

Inappropriate Out of Area Placements for adult mental health services

The “Inappropriate Out of Area Placements for adult mental health services” indicator requires that the NHS Foundation Trust accurately record the start and end times in accordance with detailed requirements set out in the national guidance. This is calculated as the total inappropriate out of area bed days.

Our procedures included testing a risk based sample of 25 items, and so the error rates identified from that sample should not be directly extrapolated to the population as a whole.

We identified the following errors:

- In four cases of our sample of patients’ records tested, the start or end date was not accurately recorded affecting the calculation of the published indicator.

As a result of the issues identified, we have concluded that there are errors in the calculation of the “Inappropriate Out of Area Placements for adult mental health services” indicator for the year ended 31 March 2019. We are unable to quantify the effect of these errors on the reported indicator.
The “Performance Against Mandated National Indicator Measures and Performance Thresholds” section on page QR60 of the NHS Foundation Trust’s Quality Report details the actions that the NHS Foundation Trust is taking to resolve the issues identified in its processes.

**Qualified Conclusion**

Based on the results of our procedures, except for the matters set out in the basis for qualified conclusion section of our report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- The Quality Report is not prepared in all material respects in line with the criteria set out in the ‘NHS Foundation trust annual reporting manual’ and supporting guidance.
- The Quality Report is not consistent in all material respects with the sources specified in source or list and
- The indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the ‘NHS Foundation Trust Annual Reporting Manual’ and supporting guidance.

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