ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Committee Supporting Papers	**Agenda Item**	Paper Y
Sponsoring Executive	Kathryn Lavery, Chair		
Report Author	Various		
Meeting	Board of Directors	**Date**	30 May 2024

Suggested discussion points (two or three issues for the meeting to focus on)

The following reports, received and discussed by the Quality Committee and People and Operational Development (POD) Committee are presented today to be noted by the Board of Directors:

Learning from Deaths Annual Report 2023/204 – The Quality Committee was assured that the systems, processes and mechanisms in place for learning from deaths is robust.

Guardian of Safe Working Hours Report (1 February to 31 March 2024 data) – The POD Committee was assured that there are appropriate systems and processes in place to ensure safe working hours and compliance to regulatory requirements for our trainee doctors.

Freedom to Speak Up (Q4 Report to 31 March 2024 data) – The POD Committee was assured that appropriate systems and processes were in place to manage staff incidents timely and appropriately.

Alignment to strategic objectives (indicate with an 'x' which objectives this paper supports)

Business as usual	x

Previous consideration

The documents have been presented to the People & Operational Development Committee (17 April 2024) and Quality Committee (22 May 2024).

Recommendation

The Board of Directors is asked to:

x	**CONSIDER** and note the appended reports for information

Impact

Trust Risk Register							
Board Assurance Framework							
System / Place impact							
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

Appendix (please list)

Refer to Agenda Pack B

Rotherham Doncaster and South Humber NHS Foundation Trust

Learning from Deaths Annual Report 2023-2024

Dr G Tosh
Executive Medical Director

Sharon Greensill
Deputy Director Organisational learning, Patient Safety and Inquests.

May 2024

1. INTRODUCTION

This report is an overview of mortality surveillance and learning from deaths within Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) and demonstrates the work undertaken with respect to such during this period the report also provides an outline of our future priorities.

2. NATIONAL/REIGIONAL CONTEXT

Reports by Mazars and the CQC in 2015 and 2016 respectively identified concerns regarding mortality systems management and suggested that that in some organisations, learning from deaths was not being given sufficient priority and that opportunities for improvements were missed.

The National Quality Board "National Guidance on Learning from Deaths" was published in March 2017, it outlined a standardised approach for NHS Trusts to investigate and learn from patient deaths which we have followed in RDaSH.

RDaSH is a member of the North of England Learning from Deaths Alliance which is a group of nine mental health trusts covering the area from South Yorkshire up to the border of Scotland. The Alliance shares good practice, documentation, and benchmarks quality standards in relation to mortality management with the aim to develop consistency in mortality surveillance practice across organisations. We are also a member of the Regional Mortality Meeting which includes representatives from both acute hospitals and community trusts.

3. MORTALITY SURVEILLANCE

The Trust Medical Director is the Executive Lead for Mortality and reports to both the Quality Committee and the Board of Directors. The Executive Medical Director is supported by the Deputy Director for Organisational Learning, Patient Safety and Inquests and the Medical Lead for Mortality.

3.1 MORTALITY SURVEILLANCE GROUP (MSG)

MSG oversees all aspects of mortality surveillance within the Trust, it meets bi-monthly and is chaired by the Medical Director. A Non-Executive Director with responsibility for oversight of mortality surveillance observes approximately once every 6 months. The MSG has leadership level representation from all Care Groups. In the coming months the MSG will be replaced by the Learning from Deaths and Prevention of Future Deaths Group which will incorporate Resuscitation governance.

It is a National Requirement that a Quarterly Report on mortality data is presented to the Board of Directors. This provides current data issues in relation to mortality surveillance management. It arrives there via the Quality Committee and is summarised to the board by the chair of that committee.
Between April 2023 and March 2024, the Mortality Surveillance Group meetings were held monthly for 3 meetings and then moved to bimonthly in August 2023. Only 1 meeting was quorate due to the absence of Care Group Representatives, this problem has been raised with Care Group Leadership and is being addressed; where meetings were not quorate decisions were made via email consultation to ensure quoracy and avoid delays to decision making.

3.2 MORTALITY OPERATIONAL GROUP (MOG)

MOG reports to the MSG in line with the requirements from the Learning from Deaths policy. The group is chaired by the Medical Lead for Mortality (currently a consultant psychiatrist) and meets on a weekly basis to ensure that reported deaths are considered in a timely manner.

MOG reviews the mortality information of all 'in scope' deaths that have occurred within the organisation to determine if a Structured Judgement Review (SJR) is required and to escalate any deaths to the Patient Safety Investigation team where concerns are identified and where a Serious Incident investigation/Patient Safety Incident Investigation (PSII) may be required. MOG also reviews and signs off completed Structured Judgment Reviews.

3.3 INTERNAL AUDIT 360 ASSURANCE

In February 2020 360 Assurance audit returned an outcome of 'Significant Assurance' against the policy; mapping continues to be undertaken against the 360 audit standards.

3.4 POLICIES, PROCESSES AND PROCEDURES

- Terms of Reference for MSG and MOG were reviewed in October 2023.
- As part of restructuring the MSG will be replaced by the Learning from Deaths and Prevention of Future Deaths Group and a new Terms of Reference is underway.
- The Learning from Deaths policy was reviewed and approved by the Board of Directors. on 21 February 2024. This is reviewed annually.

3.5 REPORTING DEATHS

All deaths are reported via the Ulysses Safeguard reporting system, this includes the template for the completion of SJRs and ensures that all Mortality processes are within a single system. Comprehensive guidance has been provided on how to use this system, we run Q&A sessions where required and a PowerPoint presentation has been developed detailing the key points from the Learning from Deaths Policy.

This has resulted in an ongoing decrease in the number of mortality forms being returned to the Care Groups for further information.

3.6 REVIEWING DEATHS

During 2023/24 there were 593 deaths reported on the Rotherham, Doncaster, and South Humber NHS Foundation Trust mortality Ulysses system. This is down by 111 compared to 2022/23.

This figure relates to deaths of patients from 1 April 2023 to 31 March 2024 who had contact with the Trust within 6 months prior to death.

Between April 2023 and 31 March 2024 the Mortality Operational group reviewed all 593 deaths, of all deaths reviewed in MOG, ~10% were subjected to structured judgment review (Table 1).

Table 1

Quarter	No of deaths	No of deaths reviewed	No of SJRs indicated
Quarter 1	123	123	15
Quarter 2	138	138	18
Quarter 3	158	158	17
Quarter 4	174	174	12
Total	**593**	**593**	**62**

For deaths resulting in reviews, the Trust seeks to identify if the death was due to a problem in care. The process also seeks to identify where a high standard of care was delivered and if there were areas of learning.
During the period no deaths have been found to be due to a problem in care.

3.6 CARE GROUP ASSURANCE

The Care Groups provide feedback and assurance via the Mortality Surveillance Group and they have updated their Terms of Reference to provide a consistent approach and feedback across the trust footprint.
Mortality is an agenda item in the Care Group Quality meetings. Learning from Deaths is also discussed in the Care Group Organisational Learning Forums.
The quoracy issue which has been highlighted is being considered in the new terms of reference.

4. LEARNING FROM DEATHS

During 2023/24 the Trust undertook several to develop an understanding of any problems, provide an overview of findings, triangulation of data or events and to identify any actions required. The Mortality Surveillance Group in 2023/24 received review reports into the following areas:

4.1 OLDER PEOPLE'S MENTAL HEALTH

The Mortality Surveillance group identified an apparent rise in older people's deaths in Doncaster Care Group and it was decided that a review would be undertaken of older people's deaths across all 3 relevant Care Groups.
The purpose of the review and report was to undertake a review of all 3 localities deaths and compare quarters 3 and 4 for each year.

A paper was presented to MSG in August 2023 finding:

- The review did not identify any areas of concern within older people's mental health services.
- The numbers of patients under services and deaths reported varied between Care Groups due to the differences in service specification services for each Care Group.
- Data was consistent with national averages.

4.2 MORTALITY AMONG PEOPLE WITH A MENTAL ILLNESS

Data from the Government's Office for Health Improvement and Disparities identified that between 2018 and 2020 around 40,000 people with a mental illness in England died before their 75th birthday; these deaths were compounded further by the impact of economic inequality and deprivation.
The early death rate of people with a mental illness from the most deprived groups in the population was 200 per 100,000.
For those in the most affluent groups, it was 53 per 100,000.
Mental illness and social deprivation confer a fourfold higher risk of dying by the age of 75.

A review was done of RDaSH deaths between 1 April 2022 to 31 March 2023 and data from our mortality system identified that there were 67 unexpected and unknown deaths.

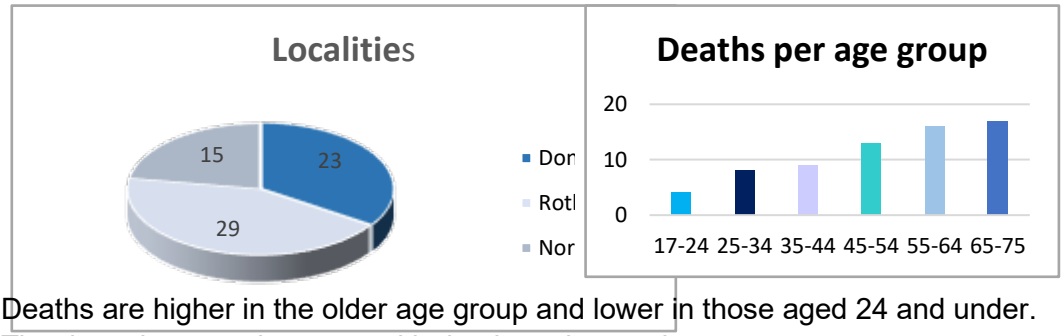
- 17 were unexpected natural deaths.
- 28 were classed as unexpected unnatural deaths.
- 22 that were logged as unknown.

A deep dive review was undertaken for the 67 deaths and cause of death is detailed in table Distribution by age and Care Group are shown in charts 1 and 2.

Table 2

Number	Cause of Death
27	Suspected suicides
10	Cause of death was not known but as no Coroner were natural causes
8	Suffered a cardiac arrest
6	Drug/alcohol related deaths
3	Sepsis
2	Misadventure
2	Pneumonia/Covid 19
2	Pulmonary embolus
2	Stroke
1	Road traffic accident
1	Sudden adult death
1	Died from choking
1	Sleep apnoea
1	Had a narrative conclusion took own life intent not known

Charts 1 and 2



Deaths are higher in the older age group and lower in those aged 24 and under.
The data shows an increase with deaths going up the ages.
A series of next steps have been identified to further interrogate and act on this raw data.

Next Steps:

- The information identified will be mapped against workstreams currently underway including the work of the Physical Health Steering Group.
- Findings will also be fed into the Community Mental Health transformation programme.
- Data will be added for smoking and alcohol/drug misuse (dual diagnosis)
- Data will be added for cancer deaths in SMI patients.
- Benchmarking data will be added.

4.3 REVIEW OF DEATHS IN NORTH LINCOLNSHIRE GROUP

Data analysis via MSG revealed a peak in deaths in North Lincs in October and December 2022 so in January 2023 a deep dive was undertaken to further understand the demographics and nature of the deaths reported.

Between October 2022 and January 2023 there were 54 deaths reported in North Lincs:

- 35 were under the Older Peoples Mental health services (OPMHS) memory service.
- 9 were under the OPMHS community team.
- 2 were deaths expected deaths of patients on end-of-life care on our older people's wards.
- 5 were under adult mental health community teams.
- 1 was under Improving Access to Psychological Therapy services (IAPT)
- 2 were under/had contact with the Crisis or Home treatment teams.
- 1 was under Learning Disability services.
- 2 were out of scope.

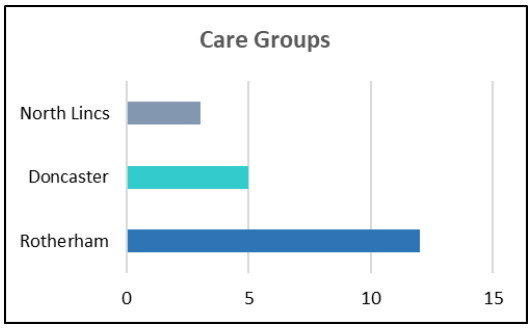
Action and Outcome

81% of the deaths were under older people's services; whilst this is high for the North Lincs area it is consistent with the data from the other care groups in relation to the services with the highest deaths. None were identified to be a death due to a problem in care.

4.4 LEARNING DISABILITIES DEATHS

20 deaths of people under Learning Disability Services reported during 2022/23 (2.5% of all deaths) - this was down from 27 in 2021/22. The were distributed across Care Groups as per Chart 3.

Chart 3



Due to the similarity in population size of Rotherham and Doncaster, the data raised the question as to whether all LD deaths under Doncaster services were being reported.

Data from Rotherham is in line with the number of LeDeR reviews submitted for the locality; however, the number for Doncaster is significantly lower than the number of LeDeR reviews submitted for the locality.

Data from Doncaster place reported 22 deaths during 2022/23 however only 5 were reported by Doncaster Care group. A request has been made for the names to identify which deaths have not been reported, we are still awaiting this data.

We have requested the same data from North Lincs and this will be reviewed when received.

Structured Judgment reviews (SJR's) were completed for the 20 deaths. The SJR's include a review against the key findings of the LeDeR as well as whether deaths were avoidable.

Place based Summary:

Rotherham: 12 Deaths reviewed; overall care was excellent and of a high standard with the following good practice highlighted.

- Regular assessments completed.
- Good liaison with care home
- Good tissue viability care plan when identified as a risk.
- Good support to care home to maintain safe practice.
- Focus on safe feeding.
    - Dysphagia assessment, risk assessments, contacted GP to change meds to liquid form to support dysphagia. Training was given to care home staff from Speech and language therapy and physiotherapy.
- Reviews by Consultant every 6 months instead of annually
- Excellent communication with parents/carers to ensure needs are identified.
- Excellent joined up working.
- Risk regularly reviewed.
- Focus on ensuing had hospital passports.

Doncaster: 5 deaths reviewed with some concerns about under reporting which are under investigation, the following areas of good practice were noted:

- Compassionate care for family
- Risk assessments regularly reviewed.
- Good communication with primary care.
- Excellent communication with internal, external agencies care providers and family.
- Good work by SALT and focus on dysphagia including risk assessments.
- Thorough physical health monitoring

North Lincs: 3 deaths reviewed the following areas of good practice were noted with one area of concern:

- Thorough physical health monitoring
- Intensive input by staff.
- Regular reviews when health declined.
- Good support to care home to maintain safe practice.
- Excellent dysphagia care plan
- Risk assessment not always completed to standard.

Recommendations

- Hospital Passports should be completed for every service user.
- Investigate potential under reporting in Doncaster.
- Ensure 100% compliance with risk assessment completion.

Next Steps

The findings will be shared with the Matron for Learning Disabilities, and the LD Quality Circle highlighting the areas for learning around hospital passports and risk assessment completion and the positive practice around communication with others and dysphagia care.

There will be a review of deaths against the Doncaster LeDeR data by the matron for Learning Disabilities and the SJR reviewers.

4.5 REGIONAL CHANGES

Medical Examiners

A new statutory medical examiner system is being rolled out across England and Wales to provide independent scrutiny of deaths and to give bereaved people a voice.

From 9 September 2024 all deaths in any health setting that are not investigated by a coroner will be reviewed by NHS medical examiners.

Well in advance of the September deadline, RDaSH have gone active with the local medical examiners' process and it appears to be working well, following discussions Doncaster medical examiner's office will serve as the single point of contact for ME services across the Trust.

Next Steps

- The Executive Medical Director will write to the ICB's to confirm that the Trust is compliant with reporting requirements.
- A date is being sought to co-deliver training with the ME office for all doctors in the Trust.

4.6 NATIONAL

Regulation 28 reports.

As part of an Inquest the Coroner will consider if there are any concerns that create a risk to others in the future and has a duty to make a report to prevent future deaths which is provided under regulation 28 Coroners (Inquests) Regulations 2013.

We review all Regulation 28 notices issued to other organisations and categorised these into topic areas for presentation at the MSG meeting. Where appropriate they are also shared with other groups in the Trust (e.g., pressure ulcer harm reduction meeting, ERICA).

The papers are circulated to all Care Groups for consideration in their meetings; allowing them to have sight on risks that are identified elsewhere and to ask the question: C*ould it happen here?*

4.7 POINTS OF LEARNING IDENTIFIED VIA SIS AND INQUESTS

When a Serious Incident investigation and a Coroner's inquest take place sometimes coincidental learning points are raised that had no bearing on the death in question but which could help prevent future deaths, the following are some examples of learning for the Trust that has been identified and the action we subsequently took.

LEARNING	**What have we done?**
We identified that letters sent to patients who were waiting for gateway assessments didn't contain details of the Crisis team.	Letters have now been amended not only to include details of the crisis team but also to include details of 'wrap around support including safe space, Andy's man club and other organisations.

LEARNING	**What have we done?**
A patient who had a long history of substance misuse was offered support from services and a pattern emerged where he was wanting help, this was being provided however he would ultimately not engage with services	Services continued to try and maintain engagement. Services demonstrated that they use varying forms of communication to try and reach people, and facilitate prompt return to services if a person feels ready to address their

	concerns

LEARNING	What have we done?
When patients disengage, we are not always proactive in trying to contact other services/organisations that are seeing that person	We have reviewed our disengagement policy and emphasised the need to both capture other services involved in the care of that person both statutory and third sector and to contact these services if someone is disengaging to try and maintain contact.

4.8 STRUCTURED JUDGMENT REVIEWS

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

- Good communication between agencies
- Care plans reflective of needs.
- Recovery focused.
- Recognition of relapse and prompt interventions
- Good physical health monitoring
- Good dysphagia care and SALT intervention
- Evidence of least restrictive practice
- Good pharmacy support and interventions
- Escalation of concerns to Consultant Psychiatrist when indicated

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

- Sub-standard documentation (completion, content)
- Care plans not always completed or accurate
- Lack of communication
- Lack of clarity around referral completion
- Lack of carer stress recognition and intervention
- Documentation of capacity assessments
- Updating of risk assessment was not robust at times

This learning has been shared through monthly Clinical Learning briefs.

During 2024/25 the Structured Judgment and PSII reviewers will be exploring further ways to learn from deaths and better cascade the learning to staff. A meeting has been set up in May 2024 to explore options and learn from other organisations.

5. SUICIDE PREVENTION

As a core aspect of suicide prevention, the NCISH recommends the adoption and embedding of national evidence including NCISH "10 ways to improve safety". As part of the standard ongoing review, the Trust maps itself against the 10 ways to improve safety and here is ongoing work as part of the suicide prevention workstream.

In recent years our work has included:

- Work with families with lived experience.
- Monitoring Regulation 28 notices given to other organisations and published nationally.
- Deep dives or thematic analysis undertaken when trends or concerns are identified.
- Strong partnership and cross organisational working around substance misuse and mental health.
- Use of Environmental Risks in Clinical Areas group (ERICA) to address any environment risks.
- A full review of ligature risks assessments for the adult mental health in patient wards.
- All deaths reviewed by the Mortality Operational Group.
- Works alongside partner agencies both at place and ICS levels.
- The Trust Lead and Care Group representatives are linked into several working groups including self-harm, drug and alcohol deaths, and deaths where physical health featured in risk factors.
- Introduction of a daily incident meeting which monitors self-harm incidents.
- Implementation of Patient Safety Incident Response Framework (PSIRF)
- Further examples of application of the 10 ways to improve safety can be seen in Appendix 1.

6. SERIOUS INCIDENT INVESTIGATIONS

46 serious incident/patient safety incident investigations were undertaken in 2023/24, this is equal to the number reported from the previous year.
Of the 46 - 33 were reported under the serious incident framework (up to 31/12/23) and 13 were reported under the Patient Safety Incident Response Framework (commenced 01/01/24).

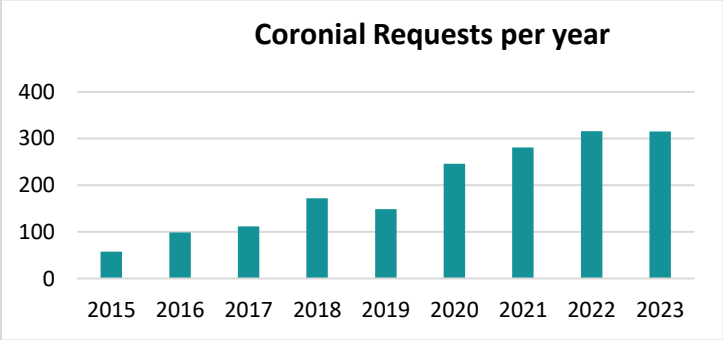
7. CORONER INQUESTS

Doncaster and Rotherham fall under the jurisdiction of the HM Senior Coroner for South Yorkshire (East). North Lincolnshire falls under the jurisdiction of the HM Acting Senior Coroner for Grimsby, and North Lincolnshire.

Following a death the coroner's office will request information on the Trust's contact with the person who has died and requests are made for statements where relevant.

The data in Chart 4 below shows the number of patients where the Trust has received enquires/requests from HM Coroner's office.

Chart 4



This chart demonstrates the year-on-year increase in enquiries and requests for statements from HM Coroners offices. Data so far from 2023/24 shows a continued increasing number of requests for information following the death of a person.

7.1 STATEMENTS TO THE CORONER

The Trust provides several statements to the HM Coroner in relation to deaths of patients who have had contact with our services, these are then considered as part of the overall evidence and are either read out by the Coroner under Rule 23 of the Coroner's Act or the staff member is called to give live evidence in court.

Between April 2023 and March 2024, the Trust has provided 269 statements for the court.
69 (26%) of these were prepared by the Deputy Director for Organisational Learning, Patient Safety and Inquests; this function of the role saves a huge amount of front-line clinical time and a consistency to the reports which has been commended by the coroner.

Table 3 – Summary of Inquest Attendance

Year	Total number	inquests lasting more than 1 day	Inquests attended	Inquests stepped down
April 2023 to March 2024	139 *This is an increase of 13 from 2022/23.*	3	42 Up 6 from 2023/23	91

7.2 REGULATION 28 REPORTS

As part of an Inquest the Coroner will consider if there are any concerns that create a risk to others in the future and has a duty to make a report to prevent future deaths which is provided under regulation 28 Coroners (Inquests) Regulations 2013.
During the period April 2023 and March 2024 received one Regulation 28 from the coroner, it was received on the 4th of October 2023 and was in relation to the death of a young man who died from heroin and cocaine toxicity.

The coroner had two concerns, the first related to 'no effective follow-up in relation to the cessation of the antipsychotic Olanzapine' and the second related to 'failure to contact a voluntary sector partner at an earlier stage to conduct a wellbeing check as they had a key to his property'.
These concerns were made in the interest of preventing future deaths and we were advised to act; the coroner did not feel that in this case that a different approach would have had an impact on the outcome.

On the 28th of November 2024 the CEO responded to the coroner detailing the actions we were planning to take with the following assurances:

- *We will be entirely changing our current Disengagement Policy and reframing it to an Engagement policy.*
- *The learning from this death will be the focus of our Trust-wide Clinical Learning Brief, which will be shared with all employees across the Trust electronically. The focus will be on discharge, engagement, and partnership working.*
- From a Clinical Perspective the Medical Director explained that cessation of Olanzapine was the patient's choice and that we had no powers to force continued compliance in such circumstances.

As a result, the Trust has a new Engagement and Disengagement Policy due for implementation, the consultation for this closed on the 30/04/2024.
Safe discharge, engagement and partnership working have yet to be included in a Clinical Learning Brief this has been necessarily delayed so that guidance and learning can be in line with and refer to the new policy.

8. FUTURE FOCUS FOR 2024/25

Several workstreams have been felt by MSG to be valuable areas of work and are integrated into the MSG forward plan. These include annual reports and reviews of deaths within specific areas and Learning Disability deaths.

Suicide Prevention

Training and development for staff against competencies once these have been published.

Structured Judgment reviews

Triangulate learning from the SJRs with PSIRF reviews, complaints and claims.

Learning Disability deaths

Continue to undertake a collective review of learning Disability deaths to identify any themes, trends, and demographics and undertake a deep dive of Doncaster LD deaths to map under reporting that has been identified.

Dr Graeme Tosh & Sharon Greensill
May 2024

Appendix 1

10 WAYS TO IMPROVE SAFETY	
SAFER WARDS	
Ligature points and policy	• Work has been done around ligatures and a review undertaken of all in patient mental health and Forensic ligature assessments. The Trust will transfer to the new Care Quality commission Ligature risk assessment template from 1 April 2024. • Addressing the environment issues which provide the opportunity for ligature, through a risk reduction/harm minimisation programme of building work is discussed in ERICA group to ensure robust governance and oversight. • Joint review meetings have been set up in localities to be held on site and include Estates, Health and Safety, Patient Safety and Care Groups.
Observations	• In March 2021, the Trust teamed up with Oxehealth, a company that provides patient monitoring systems. The innovative technology called Oxevision. • Supportive therapeutic observation is one of the Trust's key audit programmes
Ward entry and exit	Ward and building access are subject to a further review during March 2024.
Environmental management	• There has been a redesign of the seclusion areas. This focuses on both risk and safety and patient need. • All internal bathroom doors have saloon type doors. These are load release doors that also consider patients' privacy and dignity as well as safety. • Ward and building access have been reviewed across the Trust. In North Lincs and Rotherham additional controlled access doors have been installed to provide a further level of safety
Safer Staffing Levels	• Each month, the Care Groups discuss inpatient wards safe staffing at their Quality and Safety Governance meetings. • The Trust has a patient flow team and staffing is discussed in Trust wide meetings twice daily.
Multi professional working	• Working with partner organisations remains a key intervention within services. A focus has been on developing closer relationships with services such as Drug and Alcohol services.
EARLY FOLLOW-UP ON DISCHARGE	• The Trust has a model in place for 72-hour follow up. This is monitored centrally as a performance indicator and information shared with Care Groups for monitoring compliance.
CARE PLANNING AND DELIVERY	• SOPs have been developed with the patient flow team leading on development to ensure safe, smooth processes and transitions for patients. CMHT's have a duty system is in place with at least one staff member on duty each day. • Red/Amber/ Green (RAG) Ratings are being used in Adult Mental Health services. The RAG rating system is utilised in decision making for frequency of visits, complexity, and risk. • There is an ongoing transformation review of Crisis, Home Treatment and Liaisons services
NO OUT OF AREA ADMISSIONS	All attempts are made to keep patients within the RDaSH footprint. The patient flow teams manage and oversee the movement of patients to out of area beds.
24-HOUR CRISIS	• Each locality has a 24-hour crisis resolution/home treatment team (CRHT) with sufficiently experienced staff. All crisis responses moved to a single telephone contact in each care group.

RESOLUTION/HTT	• To ensure clarity around process and MHA, a flow chart has been developed with clear instructions to follow when a Mental Health Act Assessment is requested. • Training has been provided to on call managers and doctors in relation to any specific mental health act areas including Section 140 special urgency. • There is now a dedicated service for perinatal mental health. • Crisis teams have collated details of all neighboring services Crisis and liaison services to ensure robust transferer and any information sharing.
 **FAMILY INVOLVEMENT**	• Families are invited to be part of the PSIRF process which allows them to contribute to any learning. • Bereavement support is available to all families from the place base/ICS model. • The Trust is looking at how work can be done with families with lived experience
 **RISK MANAGEMENT**	• Work done on risk management and assessment. Training provided places a focus on formulation and not solely on the completion of a checklist. • Training has been reviewed and a need for s more intensive level of training for some staff groups has been identified. • A task and finish group has been sent up with a plan to work with the training providers to review the higher level of training. • The Trust Is linking with other organisations and involved with a national forum which is looking at Risk Assessments
 **OUTREACH TEAMS**	The trust has an outreach team in each locality that provides intensive support to patients who are difficult to engage or who may lose contact with traditional services.
 **SERVICES FOR DUAL DIAGNOSIS**	• In Doncaster, Drug and Alcohol services are delivered by RDaSH and there is a clear process for referral and assessment. Links have been developed in North Lincs with the third sector providers who will carry out in patient assessments. • In North Lincs there is a good relationship between services and in reach to the wards • Rotherham has a new Drug and Alcohol provider, and the care group are working with the provider to ensure that pathways and joint working arrangements in place previously are maintained. Meetings are held monthly
 **SELF-HARM**	There is 24-hour access to specialist assessment and follow-up for all self-harm patients. All patients presenting at A&E for mental health issues receive psychosocial assessment and are provided with details of a forward plan. This includes contact numbers and details of support networks to minimize the risk at times of crisis.
 **INFORMATION AND SUPPORT FOR SERVICE USERS AND CARERS**	• The Trust has developed a brief guide following relationship breakdown. • All teams have developed leaflets and secondary services have a welcome to the team pack. • The trust has developed several ways of communication with patient and carers using digital platforms and the use of apps to support patient safety planning and engagement.
TRUST DRIVEN WORK	• The Trust monitors monthly through the Mortality Surveillance groups, Regulation 28 notices given to other organisations and published nationally. • Deep dives are undertaken as and when required – a review is currently being undertaken of deaths under Crisis/Home treatment teams. • Thematic analysis is done as and when required

Rotherham Doncaster and South Humber NHS Foundation Trust

Guardian of Safe Working Hours (GoSWH)'s Report on Doctors in Training

01 February 2024
to
31 March 2024

Dr Babur Yusufi
Guardian of Safe Working Hours

April 2024

RDaSH leading the way with care

Executive Summary

This report only covers a period of two months; from 1 February 2024 to 31 March 2024.

In this report, Guardian of Safe Working Hours (GoSWH) provides details of trainees currently subject to TCS 2016/2019, information on exception reporting, on-call related provisions in work schedule and the levying of fines, concerns raised by the trainees around safety and work environment and action taken and further recommendations resulting from the above. He shows tables of exception reports and comments on any relevant trends. In addition, the GoSWH provides a summary of key issues discussed at recent Junior Doctors' Forum and related meetings.

In April 2024, there were fifty-four trainees working in the Trust, with five vacant posts.

There was a total of twenty-six exceptions reported, over a two-month period: thirteen in Rotherham, seven in Doncaster and six in North Lincs. Ther is a reduction of four ERs from the preceding two months. Most Exception Reports were for Breech of Rest Periods and Excess Hours worked during On-call, with highest numbers from Rotherham (11) followed by Doncaster (6) and North Lincolnshire (5). There were two Immediate Safety Concern report in this period, which were managed efficiently and effectively.

Time-off in Lieu (TOIL) was taken for all breaches of rest periods during On-call, except one where the outcome was not clear. TOIL was also agreed for working beyond contracted hours during daytime and extra time spent in on-call handover. Payment was agreed for one breach.

There were no ERs of missed educational opportunities or major gaps in the Rota.

There has been a deterioration in clinical supervisors'/ trainees' engagement with the ER process as 11 out of 26 ERs (42%) were not properly actioned, as against 33% in the last report.

ER trends, once again, show higher contractual rest breaches in Rotherham, while there is modest increase in Doncaster and reduction in North Lincs.

There was a 1st On-Call monitoring in the Trust for three weeks in January. The results showed gross breaches of mandatory rest conditions in Rotherham and North Lincs, following which a Task and Finish Group was constituted to work towards a rota re-design, which should be implemented for the doctors starting in August this year. In the interim, safety measures, such as additional rest hours, have been implemented to ensure the safety of doctors and patients.

Actions from the JDF in March are; (1) 1st On-Call doctors not to entertain any prescription requests for the community patients and refer them to the Consultant On-Call (2) On-Call log forms not to be completed anymore (3) Verbal Handover, alongside Electronic Handover not be required (4) Invites for JDF will be sent to all junior doctors in the Trust.

Areas for urgent attention are (1) Appropriate Admin Support for GoSWH's day to day work (2) Trainees/ Clinical Supervisors' full engagement with Exception Reporting Process; especially in absence of On-Call Log Forms (3) Implementation of GoSWH's Fines (4) Fast-tracking work to have the new rota ready in Rotherham and North Lincs, for the doctors starting in August 2024.

Introduction

The 2016 Terms and Conditions of Service for NHS Doctors and Dentists in Training England (TCS 2016) were introduced nationally on 05 October 2016. Since August 2017 the Trust has had higher trainees, core trainees, foundation trainees and GPVT trainees taking up TCS 2016. Most trainees are now subject to TCS 2016.

In this report, Guardian of Safe Working Hours (GoSWH) provides details of trainees currently subject to TCS 2016/2019, information on exception reporting, on-call related provisions in work schedule and the levying of fines, concerns raised by the trainees around safety and work environment and action taken and further recommendations resulting from the above. He shows tables of exception reports and comments on any relevant trends. In addition, the GoSWH provides a summary of key issues discussed at recent Junior Doctors' Forum and other related meetings.

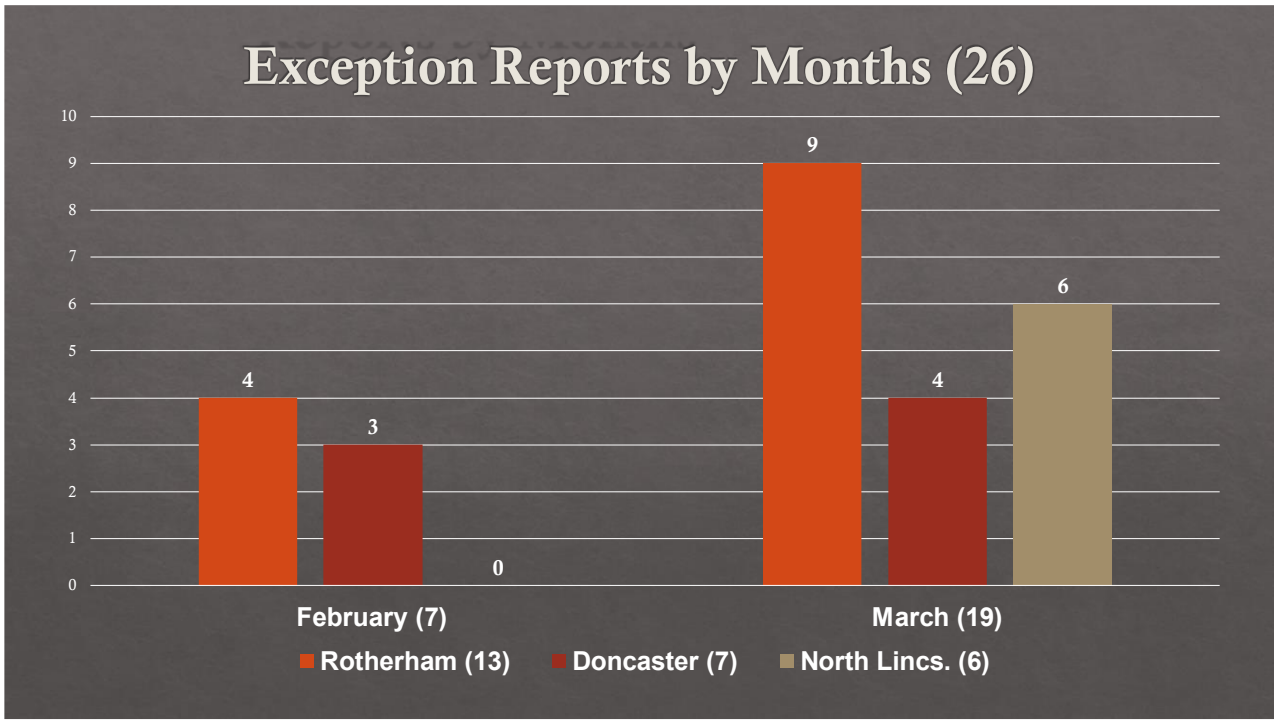
Current RDASH Doctors in Training

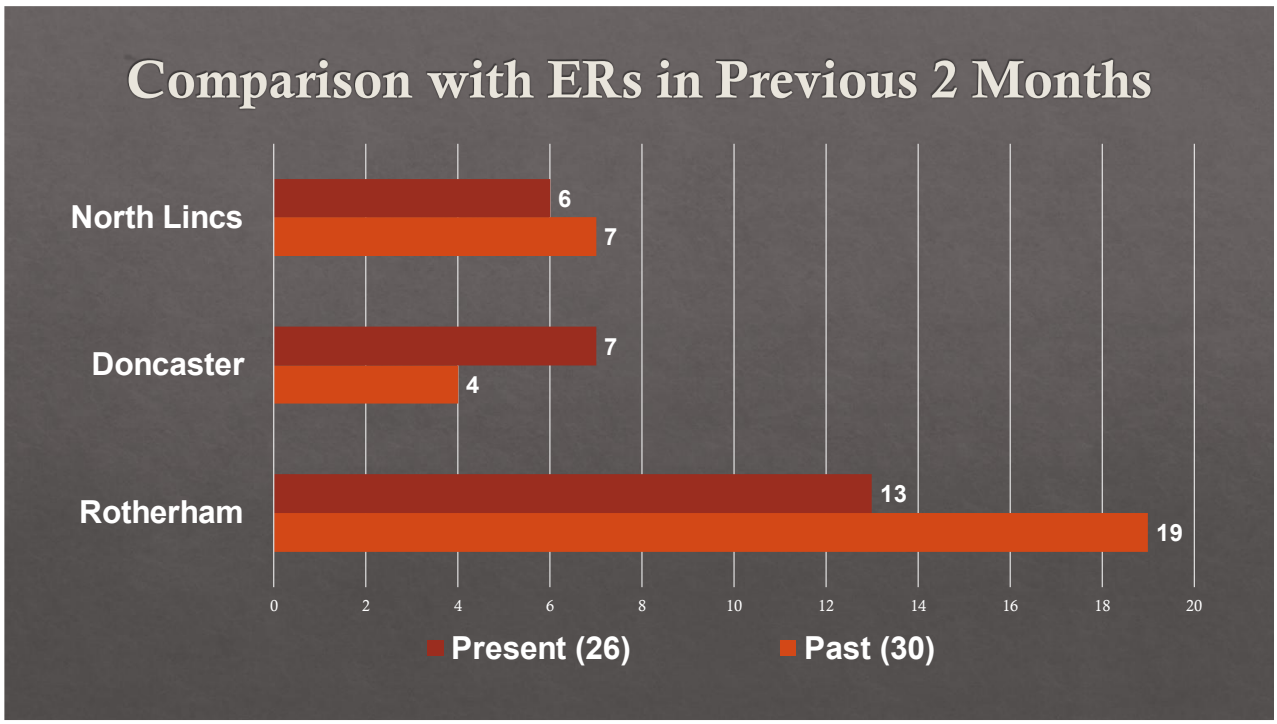
There were 54 trainees working in the trust with 5 vacant posts, from the start of the new rotation in April 2024. A breakdown of their grades is as follows:

	GP	CT	F2	F1	HT ST	**Total**	Vacant
Doncaster	4	4	2	3	6	**19**	1
Rotherham	2	13	2	4	6	**27**	1
North Lincolnshire	1	1	1	4	1	**8**	3
TOTAL	**7**	**18**	**5**	**11**	**13**	**54**	**5**

Exception Reports (ERs)

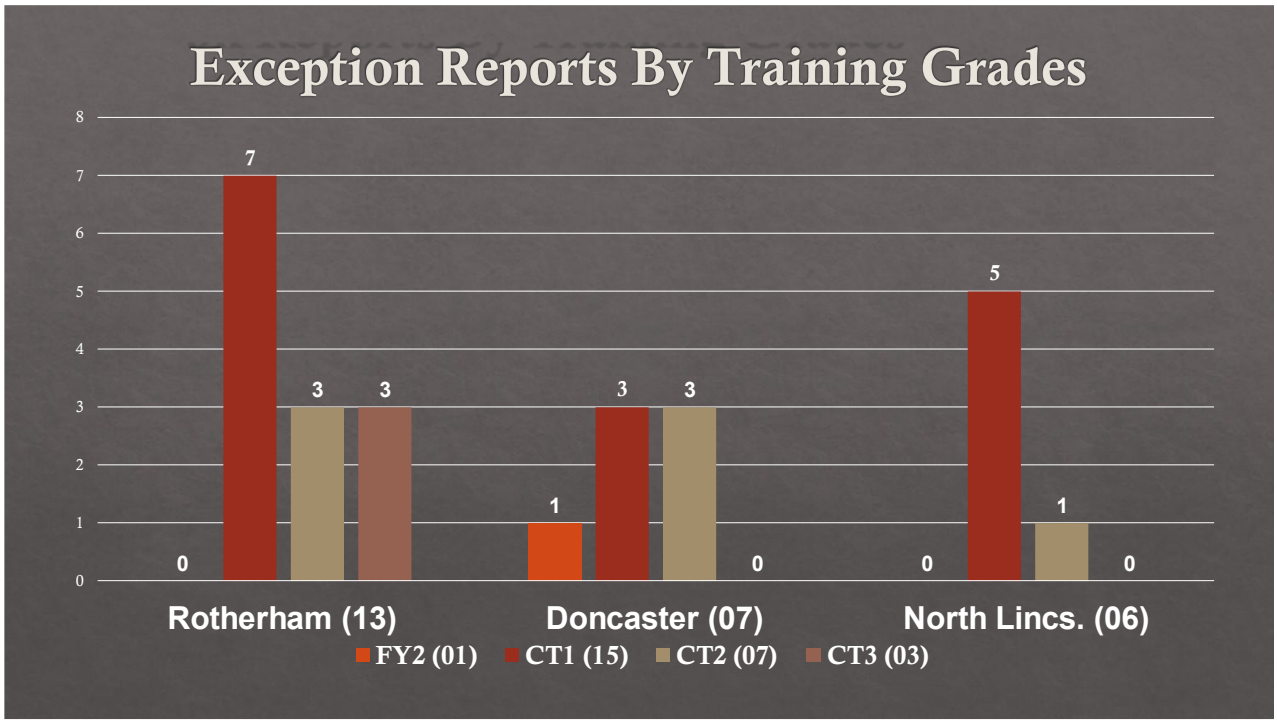
There was a total of 26 Exceptions reported from 1 February 2024 to 31 March 2024. This is 4 fewer than that reported in previous 2 months.





50% of ERs originated from Rotherham (as against 63% in the two months before), with 27% from Doncaster (as against 13% from previous period) and 23% from North Lincs (24% previously). This is a reduction in ERs from the previous months, except in Doncaster.

Rotherham, however, continues to produce most ERs.

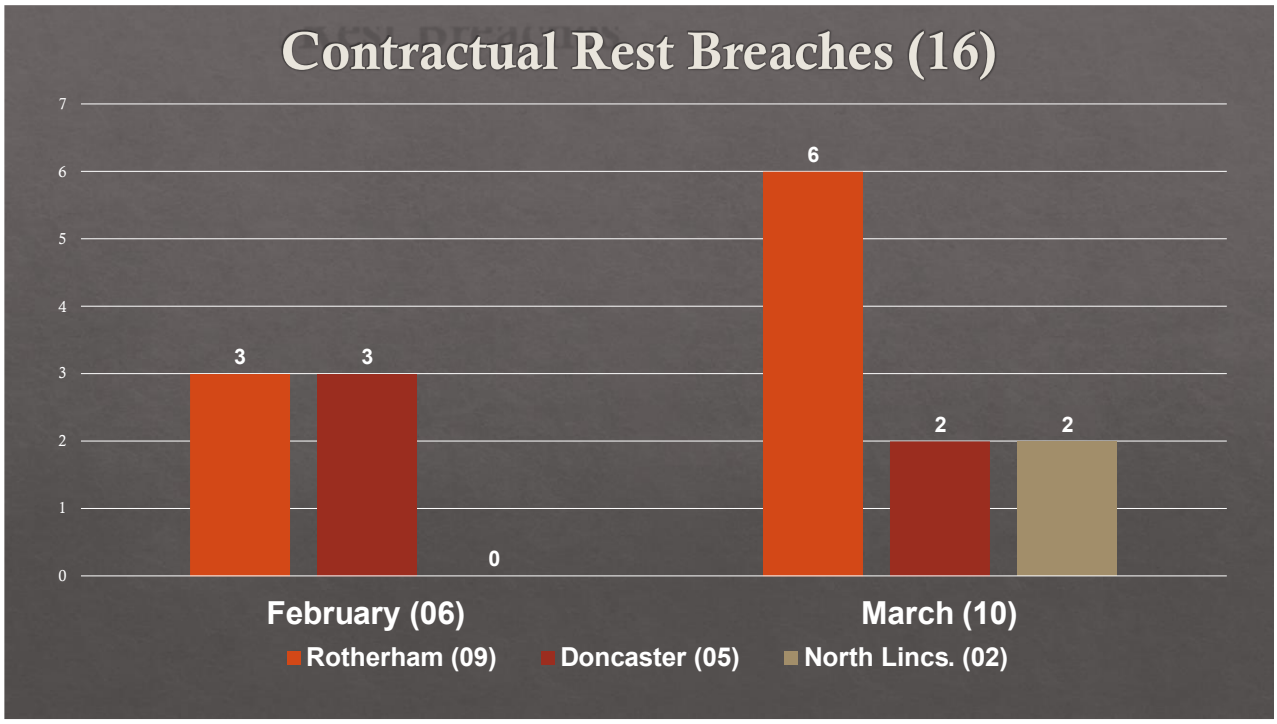


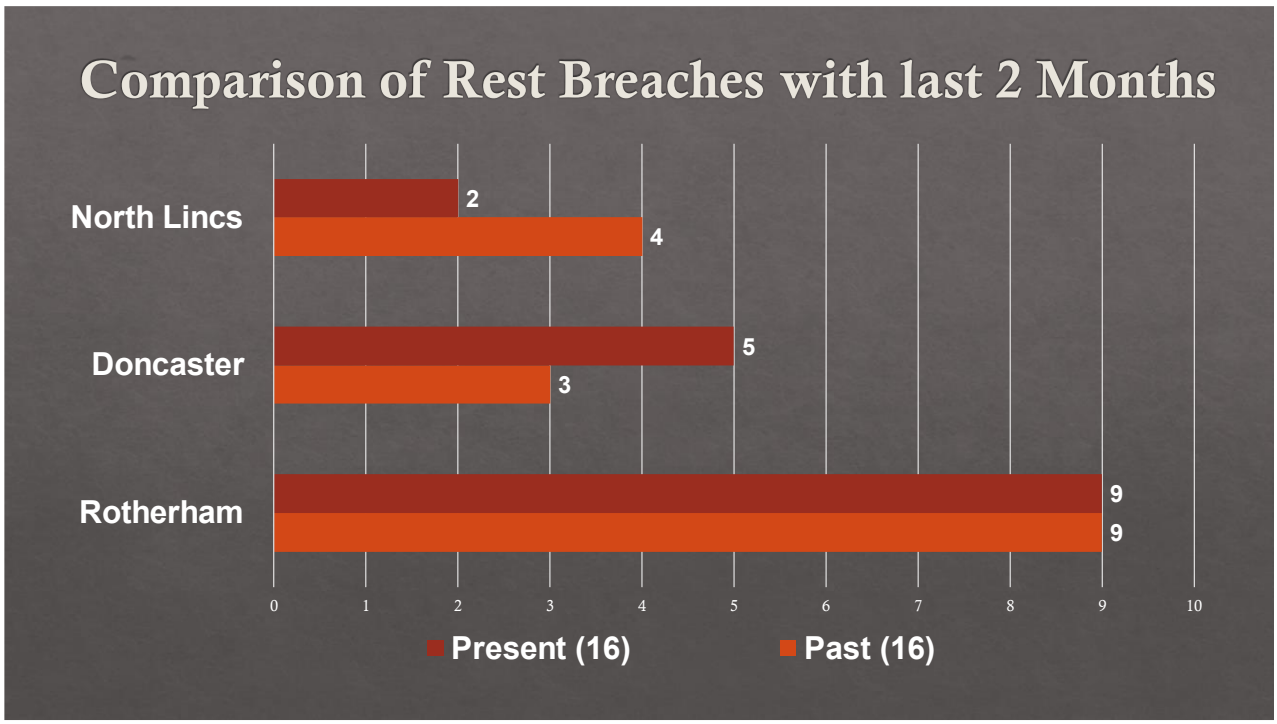
Most ERs were initiated by CT1 (58%), followed by CT2 (27%) and CT3 (11%). There were no reports submitted by the higher trainees i.e. ST.

Immediate Safety Concern

	Rotherham	Doncaster	North Lincs.
February	0	0	0
March	2 (CT = 1, CT3 = 1)	0	0

There were 2 reports of Immediate Safety Concerns, both from Rotherham. In one instance, the doctor on-call became off sick before commencing work and did not start. On other, the doctor worked for 15 hours out of 24 hours, becoming tired and needing Time Off. On both occasions the doctors were well supported by the consultants on-call and necessary steps were taken to relieve doctors and mitigate risks.



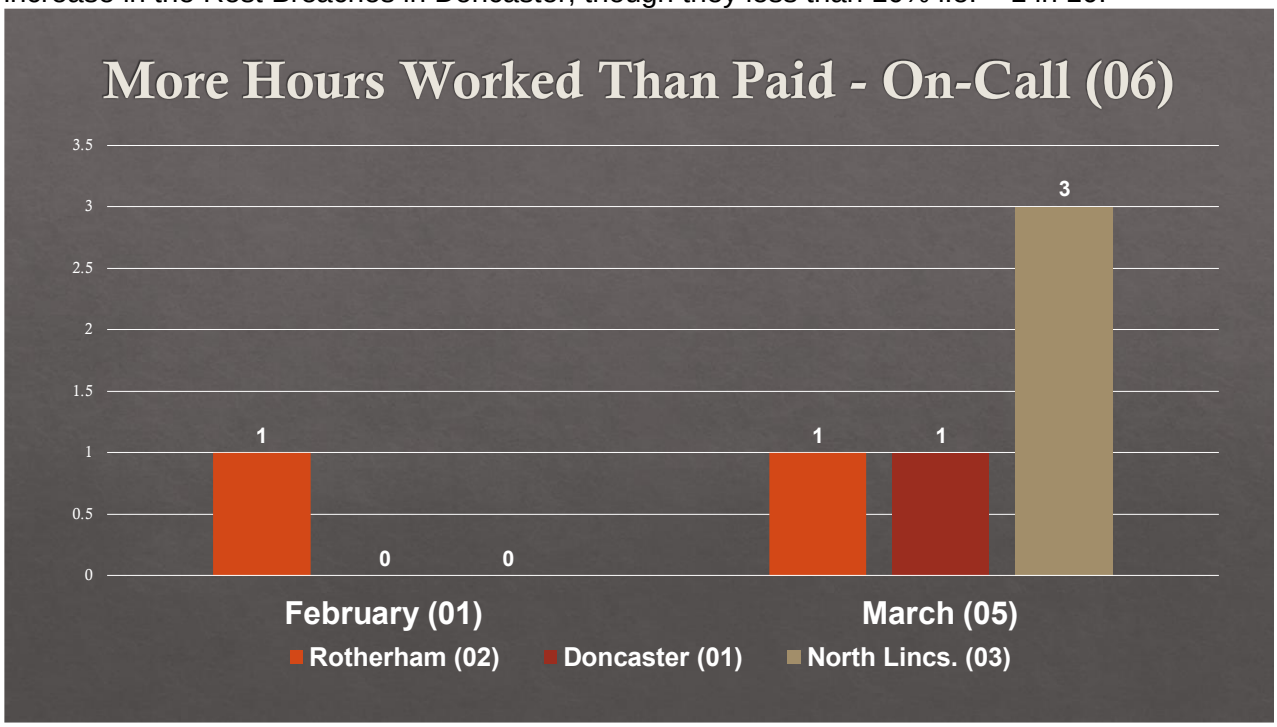


It is a contractual requirement for doctors on non-resident On-Call to avail 8 hours of rest in 24 hours, 5 hours of which should be continuous between 2200hrs and 0700hrs. Breach in these conditions results in Time Off in Lieu (within 24 hours of On-Call) or Payment in exceptional circumstances. This breach also attracts GoSWH's fine.

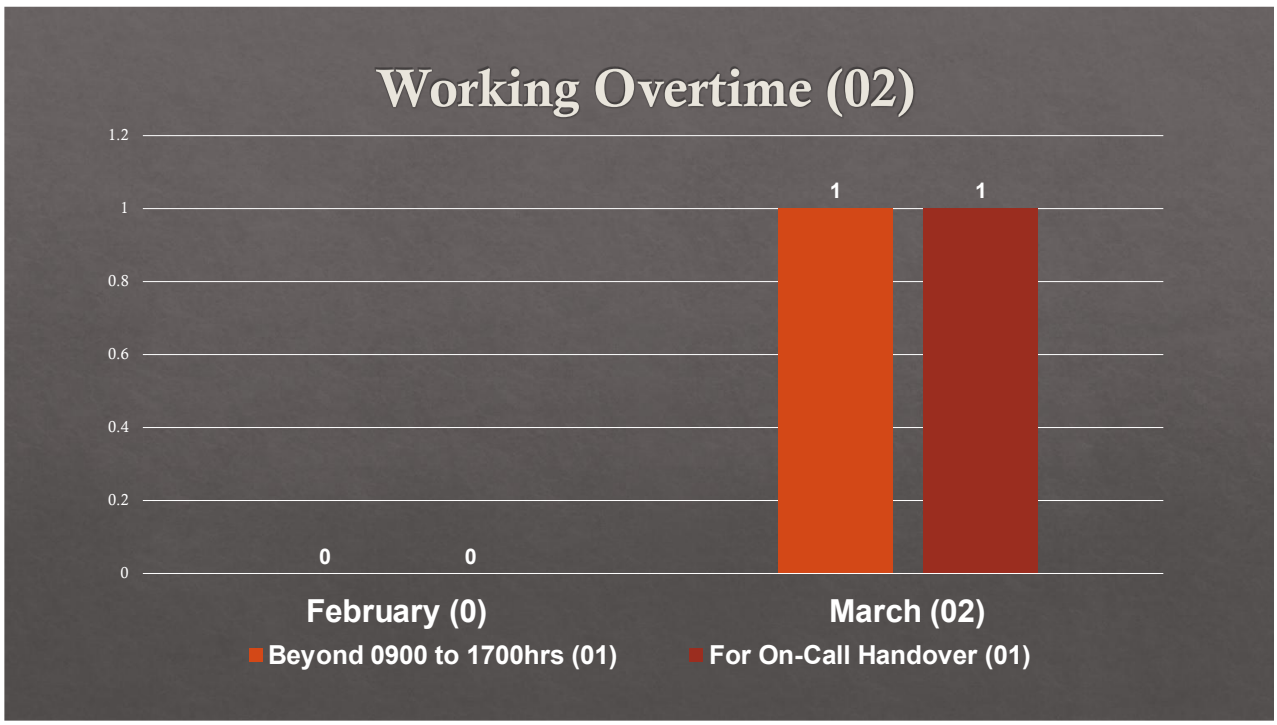
The overall number of rest breaches (n = 16) across three sites, over the period, remain the same as for the preceding 2 months. There was no change in Rotherham (56%), an increase in Doncaster (from 19% to 31%) and reduction in North Lincs (from 25% to 12.5%). The pattern observed has been.

1. 1 in 7 On-calls breached Contractual Rest Requirements in Rotherham
2. 1 in 12 On-calls breached Contractual Rest Requirements in Doncaster
3. 1 in 30 On-Calls breached Contractual Requirements in North Lincs.

Rotherham continues to remain the hot spot for the Rest Breaches. There is a trend of an increase in the Rest Breaches in Doncaster, though they less than 10% i.e. < 1 in 10.



There were also 3 fewer Exceptions reported for doctors working more hours during on-call than that paid for, as per the Work Schedule, than for last two months covered in the last report i.e. 6 vs 9. It is however to be noted, the figures given in work schedules are based on an average of number of hours worked across all on-call duties over the period of rotation and while individual variations can occur, the expectation is the average would remain the same. 50% reports were from North Lincs, and 33% and 17% from Rotherham and Doncaster, respectively.



There were 2 episodes of doctors working beyond their contracted hours, one each for working beyond 1700hrs (for 60 minutes) and staying after the completion of on-call for 25 minutes to provide handover to the inpatient teams. Time-off In Lieu was agreed on both occasions.

Exception Reports Outcomes

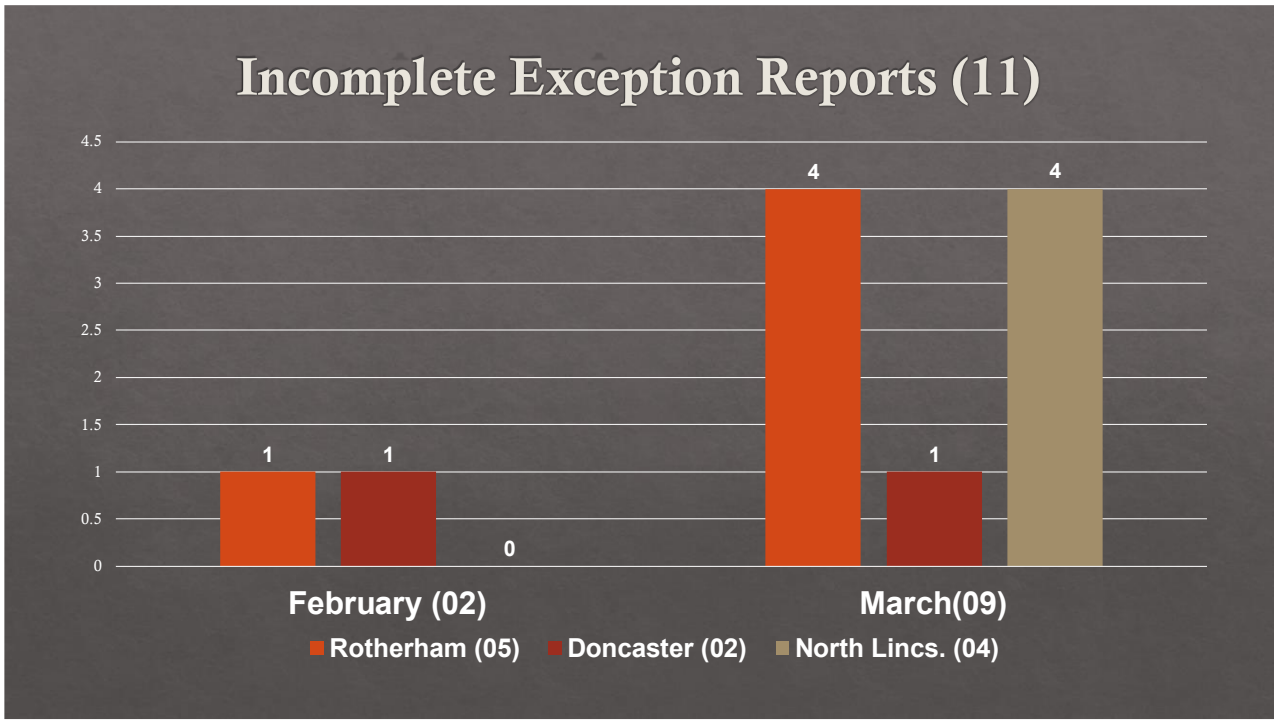
	ROTHERHAM				DONCASTER				NORTH LINCS.			
	TOIL	**Pay.**	**NA**	**NR**	**TOIL**	**Pay.**	**NA**	**NR**	**TOIL**	**Pay.**	**NA**	**NR**
Breach of Rest	08	01	X	01	05	0	X	0	02	0	X	0
Overtime (Regular Working Hours)	0	0	X	X	01	0	X	0	0	0	X	0
Overtime (On-call Handover)	0	0	X	X	X	X	X	X	01	0	X	0
More Hours Worked (On-Call)	02	X	X	X	01	X	1	X	01	X	X	02

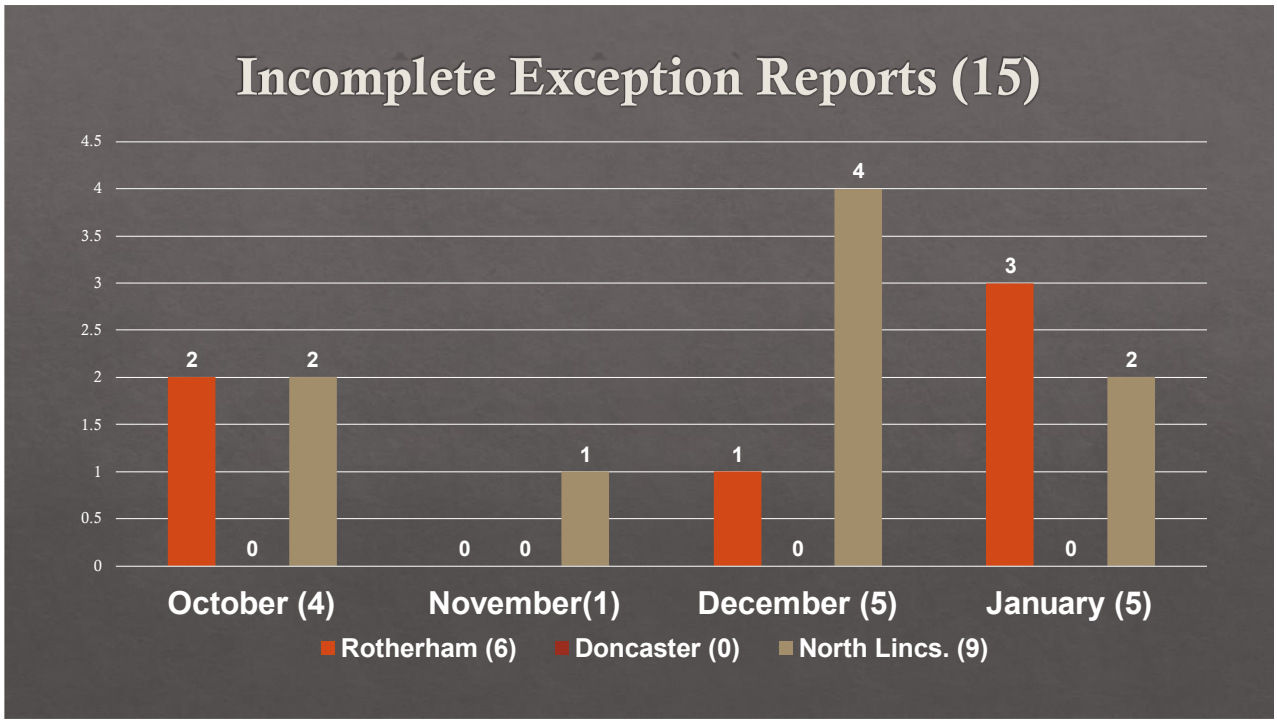
LEGEND:
TOIL = (Time Off in Lieu)
Pay. = Payment
NA = Not Applicable– No Outcome required but for Information Only
NR = Outcome Not Recorded

For Contractual Rest Breaches, Time off Lieu (TOIL) was documented on 15 (88%) occasions, payment on 1 (6%), which no outcome was recorded on 1 (6%) occasion.

Working beyond daytime work hours and for on-call handover attracted TOIL on all occasions i.e. 2 out of 2 (100%)

For working more hours during on-call than those given in Work Schedule, no immediate action was required, except for identifying GoSWH's fines for contractual rest breaches and gauging workload for further actions.





11 out of 26 (42%) Exception Reports were not completed properly, while in the preceding two months 10 out of 30 (33%) of Exception Reports were not completed by the junior doctors and their Clinical/ Educational Supervisors. There seems to a downhill trend in the completion of ERs over the last two months.

ERs not Completed (Clinical Supervisors = CS)

	CS "A"	CS "B"	CS "C"	CS "D"	CS "E"	CS "F"	CS "G"	CS "H"
Rotherham	2	1	1	1	XXX	XXX	XXX	XXX
Doncaster	XXX	XXX	XXX	XXX	1	1	XXX	XXX
North Lincs.	XXX	XXX	XXX	XXX	XXX	XXX	3	1
Total ERs Not Completed =11 out of 26 (42%)								

While 6 of 8 Clinical Supervisors have not completed the process for once only, there are two Clinical Supervisors, who have not completed 2 and 3 ERs, each.

Trends in Exception Reporting

Following trends have been observed:

1. There are two Immediate Safety Concerns reports. Both were appropriate and managed effectively as soon as concerns came to fore. Consultants on-call were supportive of their junior doctor colleagues and all practical steps were taken to mitigate risks.

2. Rotherham remains on top once it comes to On-call Rest Breaches, followed by Doncaster and North Lincs.

3. There are fewer reports of working more hours while on-call than work scheduled since the last report and most originate from North Lincs, following by Rotherham and Doncaster.

4. There is a significant reduction in doctors working beyond 9 to 5.

5. Almost all the Exceptions were resolved satisfactorily through Time Off in Lieu (TOIL) or payment.

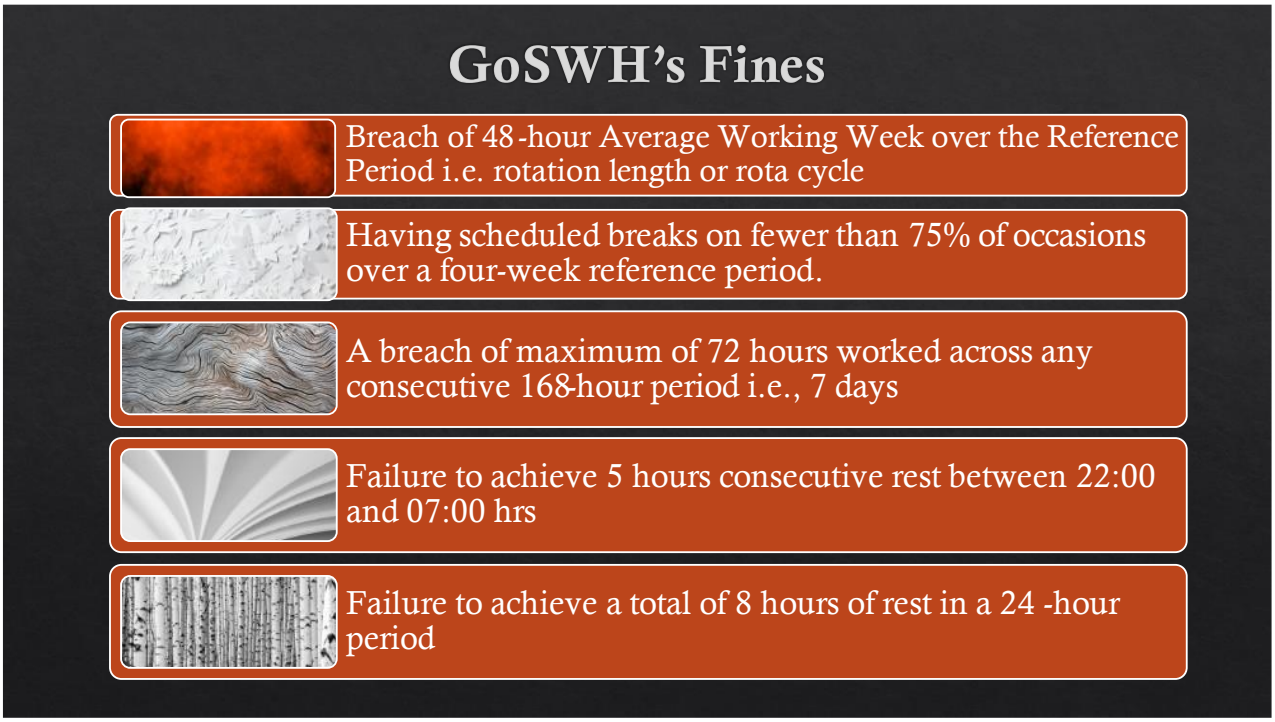
6. There were no reports for Missed Educational Opportunity

7. A major concern is almost 42% of Exception Reports were not processed properly, by the Junior doctors and their Clinical Supervisors. GoSWH have continued to impress upon the contractual requirement and need for completing the ERs properly and will continue to do so.

There were no rota gaps identified.

GoSWH's Fines:

The following breaches results in GoSWH's Fines.



67 Fines for confirmed **Mandatory Rest Breaches**, from **9 February 2023** to **31 December 2023** have been authorized by the GoSWH.

Medical Staffing are working with RDaSH Finance for the implementation.

1st On-Call Monitoring and Rota Design

1st On-Call Workload monitoring was carried out between 05/01/2024 and 4/2/2024 (Total = 21 Days. The return rate for On-Call log forms was as follows.

1. Rotherham = 71%
2. Doncaster = 81%
3. North Lincs = 86%

The results are as follows.

Rotherham		
	Apr – May 2023	**Jan – Feb 2024**
5-hour Rest Breach	36%	53% (1 in 2) (Increased)
No. of Hrs worked during On-Call	5 hrs 58 mins	3 hrs 28 mins (Reduced)
Inappropriate Calls = 4 out of 24 (17%)		

North Lincs		
	Apr – May 2023	**Jan – Feb 2024**
5-hour Rest Breach	25%	28% (approx. 1 in 3) (Increased)
No. of Hrs worked during On-Call	2 hrs 32 mins	3 hrs 13 mins (Increased)
Inappropriate Calls = 3 out of 10 (30%)		

Doncaster		
	Apr – May 2023	**Jan – Feb 2024**
5-hour Rest Breach	19%	6% (approx. 1 in 20) (Decreased)
No. of Hrs worked during On-Call	4 hrs 39 mins	1 hr 57 mins (Decreased)
Inappropriate Calls = 0 out of 1 (0%)		

An urgent Extraordinary Junior Doctors' Forum (JDF) was organized and following was agreed.

1. **Rota re-design** in **Rotherham and North Lincs** was required to make it compliant and mitigate risks to the doctors and patients.
2. To achieve this, a **Task & Finish Group** having GoSWH as the chair and Junior Doctor Reps, Medical Staffing Team, and Care Group Medical Directors, as members, was constituted. It was decided to hold weekly meetings to finalise the Rotas before 1 May for further processing. The objective is to implement the new rota for the new doctors starting in August 2024.
3. To **mitigate risk,** following **interim arrangements** were agreed.
    - The On-Call doctor to take Half a day off on/ before the day On-call.
    - No Regular Work to be scheduled on the day following On-call.
    - In case of breach of rest, ER and take the whole day as TOIL.

Task and Finish Group:

The group comes together on Thursday every week and four meetings have been organized so far.

Following has been agreed.

1. Proposed Rota Design is as follows.

Proposed Rota Design			
Shift	**Time**	**Days**	**Post-Shift Rest**
Long Day Mon - Thu	0900 – 2130 hrs	1 in 4	Nil
Long Day Fri – Sun	0900 – 2130hrs	3 consecutive	48 Hours off
Night Mon – Thu	2100 – 0930hrs	4 consecutive	48 Hours off
Night Fri - Sun	2100 – 0930hrs	3 consecutive	48 Hours off

Long Day from Monday to Thursday i.e. doctors working after their regular hours from 1700hrs to 2130hrs, will be covered by a different doctor every day. Long days from Friday to Sunday will be covered by the same doctor. Night duties will be split into two batches; Monday to Thursday (4 consecutive nights) will be covered by one doctor and Friday to Sunday (3 consecutive nights) by another. Three doctors doing consecutive shifts will have 48 hours off at the end of their consecutive shifts.

2. All shifts will be Non-resident On-call except 1700hrs to 2130hrs in North Lincs which will be Resident On-call.

3. Renumeration for on-call work will be based on Non-resident On-call payment system.

4. The Trust will ensure On-call accommodation is up to the mark, in case a doctor has to use it.

Further work is required in the following areas.

1. Medical Staffing and Junior Doctors' Reps, with support from BMA Industrial Relations Officer will confirm that the proposed On-Call Rota System is compatible with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 and the subsequent revision in 2019.
2. Medical Staffing to confirm that the proposed Rota Design is feasible for implementation in Rotherham and North Lincs through creations of dummy rotas. Mr. Duncan Marr, Medical Directorate and Medical Education Manager is working on a dummy rota for North Lincs, while Allocate (Rota Rostering Software used by the Trust) have been commissioned to create such rotas by 17 April.
3. The proposal that newly inducted international doctors in the Trust may be utilized to fill any rota gaps will be considered by the two Care Group Medical Directors, if required.
4. Medical Staffing to consider measures to cover rota gaps through use of locums.

5. Appropriate personnel to complete Quality and Safety Impact Assessments related to training, progression towards ARCP, clinical duties and work (as given in the Work Schedule) and general impact on the services once the rota design is finalized.
6. Assessment of impact on less than full time trainees by Medical Staffing
7. Costing of Rota by the Finance Department.

Above is a work in progress and will be reported on in the next report.

Junior Doctors' Forum (JDF)

JDF was convened on Thursday 21 March and following decisions were made.

1. 1st On-Call doctors will not entertain any prescription requests for the community patients, and refer them to the Consultant On-Call
2. 1st On-Call doctors will not be required to complete On-Call log forms anymore. However, they will be required to mention the hours by which the Contractual Rest Periods are breached, in Exception Reports.
3. Pre and Post On-Call Verbal Handover should not be required, along with the Electronic Handover. This was later confirmed by the Senior Medical Leadership Team and the process of modification in e-handover SOP to reflect this has been initiated.
4. Invites for JDF will be sent to all junior doctors in the Trust.

Areas for Urgent Attention

1. While support is available for specific tasks such as JDF and Exception Reporting, there is a lack of clarity around day-to-day admin support for GoSWH.

2. Trainees/ Clinical Supervisors' full engagement with Exception Reporting Process; especially in absence of On-Call Log Forms – This report highlights a significant deterioration in this area, as compared to the pervious one. A process to remind Trainees/ Clinical Supervisors to process Exceptions reported in time was started but not liked by some quarters. GoSWH will consider re-instituting the same along with other measures to improve compliance with Exception Reporting process.

3. GoSWH's Fines: GoSWH are working with the Medical Staffing to get an implementation, as soon as possible.

4. Implementation of Rota re-design in Rotherham and North Lincs – To fast-track work to have the new rota ready for the doctors starting in August 2024.

Dr Babur Yusufi
Guardian of Safe Working Hours (GoSWH) for RDaSH

Freedom to Speak Up (FTSU) Guardian

Executive Summary

This paper provides an update regarding RDaSH activity since the last Report in December 2023 (deferred from October 2023). Within the paper the results of the National Guardian's Office (NGO) data collection are presented alongside RDaSH information to provide national and regional comparison and context.

The information is a summary of more detailed information analyzed via the People committee Meeting; Operational Management Team Meeting which is monitored monthly.

The paper is presented in a structured format to ensure compliance with the – "*Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts"* published by the National Freedom to Speak Up Guardian's Office and NHS Improvement and updated in July 2019. The presentation of this information is structured in such a way that enables the FTSU office to describe arrangements by which Trust staff may raise any issues, in confidence. This may concern a range of different matters and to enable the Board to be assured that arrangements are in place for the proportionate and independent investigation of such matters and that follow-up action is taken.

Introduction

Freedom to Speak Up (FTSU) concepts continue to highlight opportunities for improvement and are taken on board at RDaSH. This biannual report is provided to the Board of Directors (BoD) Meeting, to provide assurance that FTSU processes are in place in RDaSH and are being utilised. To ensure best practice and the guidance is adhered to, the following report has been structured to provide information concerning the following, presented by the FTSU Guardian:

- Section 1 - The assessment of issues
- Section 2 - Potential patient safety or worker safety and experience issues
- Section 3 - Action taken to improve FTSU culture
- Section 4 - Learning and improvement
- Section 5 - Recommendations

Strategic context

FTSU principles are contained within the NHS contract. Research connects good "speak up" cultures with improved patient safety, higher staff wellbeing and retention, lower levels of dissatisfaction and higher care quality. The FTSU concepts embrace the following RDASH strategic goals:

- To provide safe, effective, and compassionate care.
- To attract, retain, support, and develop the finest workforce.
- To be an outstanding, well-led organisation.

Section 1 - The Assessment of FTSU Issues

Summary of FTSU concerns to date:

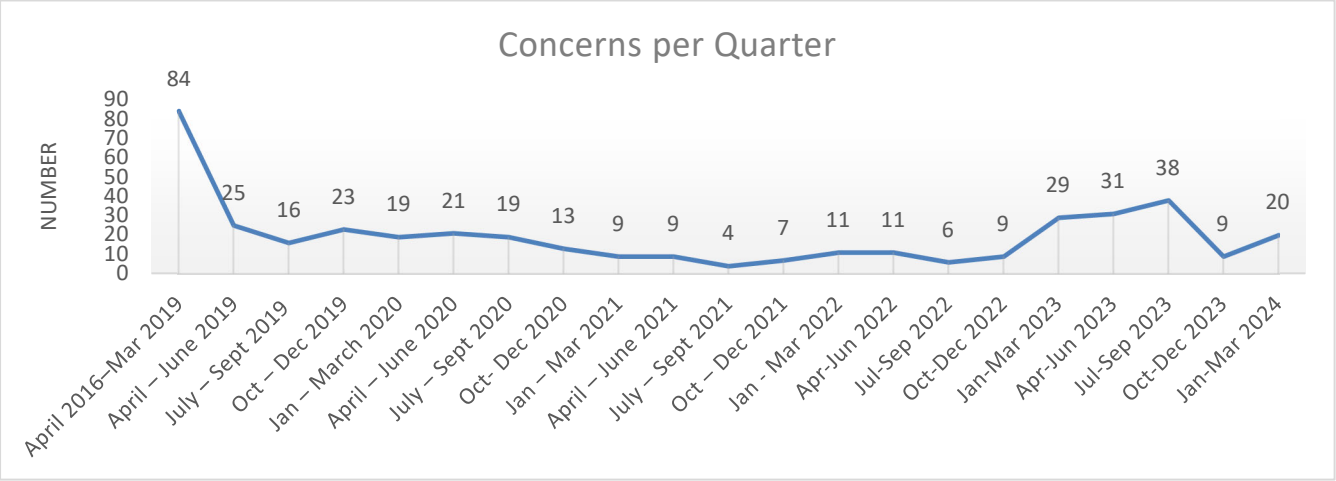
All concerns raised at RDaSH since the commencement of FTSU are provided in the tables. The previous year's concerns are highlighted to enable year on year comparisons.

Table 1: Number of FTSU concerns per Quarter

Date Period	Quarter	Number of Concerns
Apr 2016–Mar 2019	-	84
April – June 2019	1	25
July – Sept 2019	2	16
Oct – Dec 2019	3	23
Jan – March 2020	4	19
April – June 2020	1	21
July – Sept 2020	2	19
Oct- Dec 2020	3	13
Jan – Mar 2021	4	9
April – June 2021	1	9
July – Sept 2021	2	4
Oct – Dec 2021	3	7
Jan - Mar 2022	4	11
Apr-Jun 2022	1	11
Jul-Sep 2022	2	6
Oct-Dec 2022	3	9
Jan-Mar 2023	4	29
Apr-Jun 2023	1	31
Jul-Sep 2023	2	38
Oct-Dec 2023	3	9
Jan-Mar 2024	4	20
Total from 2016 to (26/03/2024)		**425**

Table 2: RDASH % comparators

Concerns per area	Number & %	Number of Staff in Locality (FTE)	Staff allocation %
Childrens	44 (10.35%)	528	14.78%
Corporate	67 (15.76%)	599	16.76%
Doncaster	176 (41.41%)	1587	44.42%
Doncaster (MH)	2 (0.47%)		
N/A	3 (0.71%)	0	0.0%
North Lincs	53 (12.47%)	242	6.77%
Not Provided	6 (1.41%)		
Rotherham	74 (17.41%)	617	17.27%
Total	**403 (100%)**	**3573**	**100%**



Comparative data

The NGO ask FTSU Guardians in all Trusts for information on FTSU concerns. Discussion concerning comparisons using the national data collection and the FTSU Guardians Survey are summarised in the sections below, drawing from the National Guardian's Office (NGO) annual data report and the Listening to Guardians Survey both published in July 2023.

The comparative and contextual data is provided below regarding the concerns that have been raised since our last report in Dec 2023.

Concern Rates

Trust concern rates are monitored on an individual basis. The concern levels fluctuate from month to month in our organisation; however, they are monitored regarding both trends and number with the full year comparison data presented by the NGO. It has been noted by the NGO (Table 3) that this is the highest number of concerns recorded – 25% increase from 2021/22

Table 3: NGO Annual Comparison	
Year 6 (2022/23)	25,382
Year 5 (2021/22)	20,362
Year 4 (2020/21)	20,388
Year 3 (2019/20)	16,999
Year 2 (2018/19)	12,255
Year 1 (2017/18)	7,087

Freedom to Speak Up Guardians collect and report anonymised data on the concerns raised with them by workers. They have handled over 100,000 concerns since the National Guardian's Office first started collecting data in 2017.

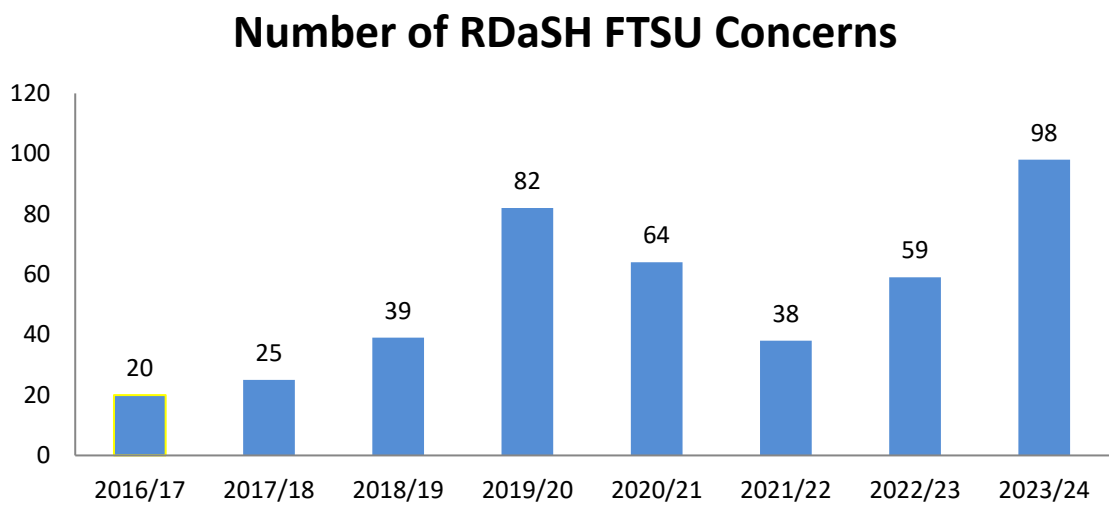
Nearly a third of concerns included an element of inappropriate behaviours and attitudes. A decrease in the percentage of concerns related to bullying or harassment (31.8 percent in 2021/22 to 21.7 percent in 2022/23) can be attributed to concerns being reported against this new category.

Over a quarter of concerns included an element of worker safety or wellbeing.

Nineteen per cent of concerns involved an element of patient safety/quality this year, up from 18.8% in 2021/22.

Despite an improvement in levels of anonymity, detriment for speaking up remains a concern. Although there has been a drop in percentage (to 3.9%) given the rise in numbers, this equates to 1,000 concerns.

The headlines from the report can be found at Appendix 1.



This year 2023/2024 shows an increased number of concerns compared to 2022/23. It is believed that the cultural interventions from the Organisational Development (OD) Team, the increased support from the FTSU Champions, Safety Huddles in 16 settings across the organisation and staff using the line manager route to raise concerns is helping to make speaking up what we do at RDaSH. We continue to promote the FTSU pathway and the learning from concerns raised is shared with individuals, at care group level and in the Safety and Quality Group. There has been a **66% increasing** the number of concerns raised to the Guardian in the year 2023/24. This could be attributed to the increase in freedom to speak up champions and also the increased visibility of the Guardian in forward facing the service.

FTSU National Guardian Survey 2023

Freedom to Speak Up Guardians have unique insight into the Speak Up culture in their organisations. Our survey of guardians shares their experiences and how speaking up arrangements are being implemented in the healthcare sector.

Since the National Guardian's Office first survey of guardians in 2017, the Freedom to Speak Up network has grown significantly. From 200 guardians, mainly in NHS trusts, there are now over 1,000 guardians working across healthcare, including primary medical services, hospices, the independent sector, and national bodies. This growth signifies the increasing recognition of the importance of Freedom to Speak Up for all organisations who want to do their best for colleagues and for people using services.

The survey takes a temperature check of the speaking up culture within organisations as perceived by Freedom to Speak Up guardians. Through their role of listening to workers and speaking truth to power, guardians have a unique insight into the health of the Speak Up culture in their organisations.

This temperature check serves as an early warning sign of cultural issues in the sector. Our report looking at the results can serve as a tool for improvement by highlighting areas of concern that impact upon worker wellbeing, retention, and ultimately, the quality and safety of care and services.

Key Findings from the FTSU Guardian survey can be found at Appendix 2

The Freedom to Speak Up Index and Staff Survey

Every year, NHS staff in trusts are invited to take part in the NHS Staff Survey to share their views about working in their organisation. The data gathered is used to monitor trends over time, as well as to compare organisational performance to improve the experiences of workers and patients.

The NHS Staff Survey has undergone significant changes – in line with the People Plan. As a result, some of the questions which made up the FTSU Index have been withdrawn. In light of this, the National Guardian's Office will no longer be publishing the FTSU Index.

The National Guardian's Office continues to work together with colleagues from NHS England and Improvement on including speaking up questions in the NHS Staff Survey. The 2022 survey included a new question asking whether workers feel safe to speak up about anything that concerns them in their organisation.

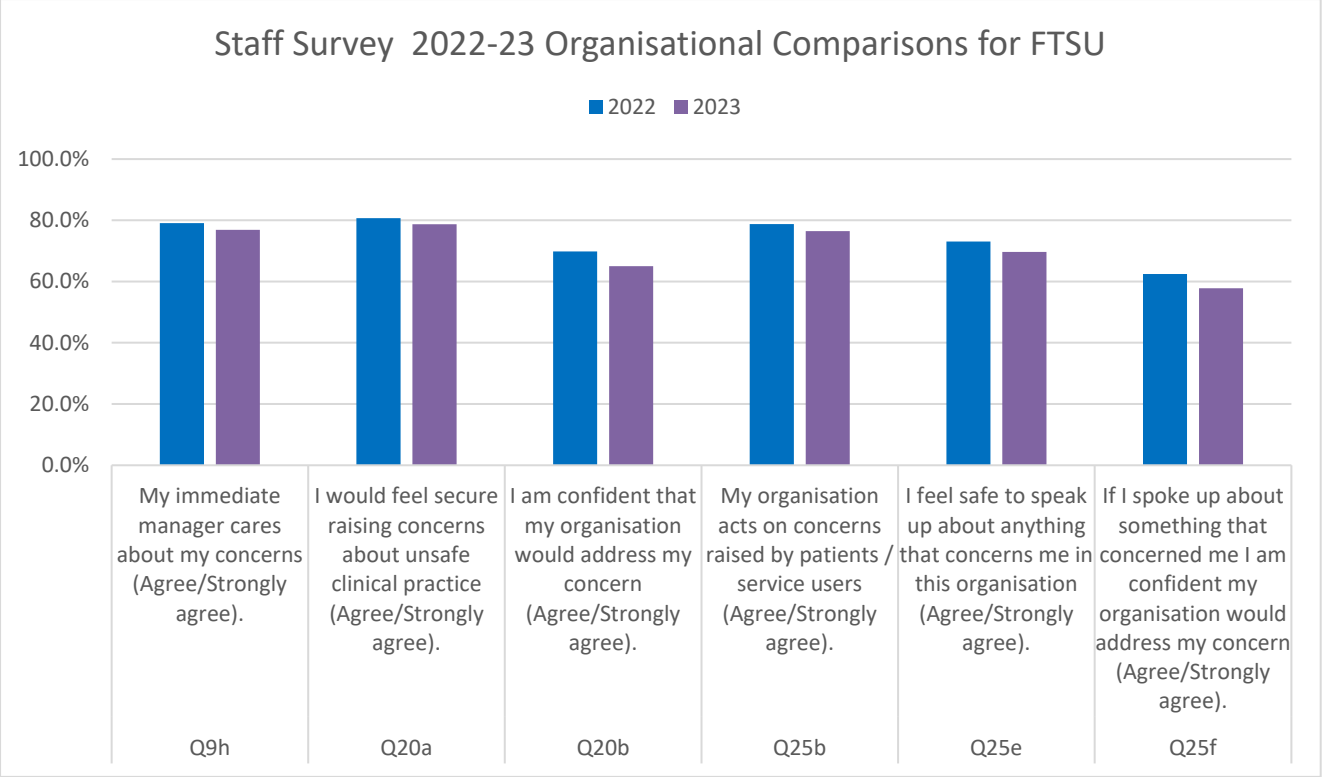
The National Guardian's Office welcomes the inclusion of these questions regarding perceptions of speaking up and invites all organisations to consider using this question as an indicator of their speaking up culture and arrangements.

Instead of publishing the FTSU Index, the National Guardian's Office will look at the results of these questions and others in the NHS Staff Survey as part of a broader and more holistic view of the speaking up landscape in healthcare. Additionally, the National Guardian's Office is working with colleagues to present the results of this year's NHS Staff Survey on the Model Health System, this will ensure Freedom to Speak Up Guardians in trusts will be able to use this tool to look at results from the survey in the same way they were able to do so with the FTSU Index.

Staff Survey 2023

In the six questions related to Freedom to Speak Up the trust has not improved in 2023 from 2022. Work will be undertaken with HR colleagues to try and drill down into this year's scores to understand if there are any areas within the organisation where confidence in raising concern is particularly poor. The Guardian will then be looking at offering bespoke session to help improve confidence in speaking up and increase knowledge. Also, in quarter 2 2024/25 half-day a learning session will be brought in for all staff within the organisation and the Guardian will be pushing for Freedom To Speak Up training to be incorporated within these sessions. The Guardian is also going through the process of requesting to speak up listen up and follow up training be made mandatory within the organisation for all staff. This will again increase staff us understand of the speaking up process as well hours giving managers and senior leaders best sound understanding of how to respond when concerns are raised within their respective areas.

Questions		Comparison	
		2022	2023
Q9h	My immediate manager cares about my concerns (Agree/Strongly agree)	79.1%	76.9%
Q20h	I would feel secure raising concerns about unsafe clinical practice (Agree/Strongly agree)	80.7%	78.7%
Q20b	I am confident that my organisation would address my concern (Agree/Strongly agree)	69.8%	65%
Q25b	My organisation acts on concerns raised by patients / service users (Agree/Strongly agree)	78.8%	76.5%
Q25e	I feel safe to speak up about anything that concerns me in this organisation (Agree/Strongly agree)	73.1%	69.6%
Q25f	If I spoke up about something that concerned me, I am confident my organisation would address my concern (Agree/Strongly agree)	62.4%	57.8%



Themes and Trends

RDASH themes and trends regarding FTSU must be published within our Board updates. The themes and concerns are presented via: Core Service (Table 4), Professional Group (Table 5) and locality, this should be viewed alongside the learning points specified in the next section.

Table 4: Number of concerns raised in total via core service (calendar year)

Core Service	Total Number of FTSU concerns (Total 425)	Number of FTSU concerns (Total 22) Nov 2023 – Mar 2024 (as at 26/03/2024)	Current CQC Rating
Substance Misuse Services	1 (0.24%)	1 (4.55%)	Good
Wards for Older Peoples with mental health problems	25 (5.88%)	2 (9.09%)	Good
Long stay or rehab wards for working age adults	14 (3.29%)	0	Requires Improvement
Community Based mental health services for adults	72 (16.94%)	1 (4.55%)	Requires Improvement
Community health inpatient services	17 (4%)	0	Good
Acute wards for adults of working age and psychiatric intensive care units	54 (12.71%)	7 (31.82%)	Requires Improvement
Specialist CAMHS	12 (2.82%)	1 (4.55%)	Good
Community Mental Health Services with LD or Autism	22 (5.18%)	2 (9.09%)	Good
Community health services for CYP and Families	35 (8.24%)	0	Outstanding

Forensic Inpatient of secure wards	15 (3.53%)	0	Good
Community Health Services for adults	38 (8.94%)	0	Requires Improvement
End of life care	0	0	Good
Community based mental health services for older people	32 (7.53%)	2 (9.09%)	Good
Mental health crisis services and health-based places of safety	6 (1.41%)	0	Outstanding
Corporate Services	69 (16.24%)	4 (18.18%)	
Other services (i.e., Nursery)	5 (1.18%)	1 (4.55%)	
Not Provided	8 (1.88%)	1 (4.55%)	

What this means at RDaSH - The data presented in table 4 (above) shows a breakdown of FTSU per core service. This enables a view of concerns that have been raised via specialisms. There has been a consistently high number of concerns raised in the Acute wards for adults of working age and psychiatric intensive care units in the previous years. Our response to these rising concerns was to offer OD interventions and hold cultural conversations in big groups and also when patient safety related escalating to the SLT within the care group and FTSU panel for further investigation.

The 58 FTSU champions and visibility of the Speak up Guardian throughout the 2023/24 and engaging with teams virtually have all helped our position. The table also demonstrates which service have had *no concerns raised*. We have engaged with these teams to listen and learn from them, and the feedback received is that colleagues in both services feel that they can speak up and they are empowered to speak up and these areas are living the RDASH way.

Table 5: Number of concerns raised in total via professional group (*financial year*)

Professional Group	RDaSH % (% to whole number) 76 concerns as at 24/11/2023	RDaSH % (% to whole number) 98 concerns as at 26/03/2024
Nurses (midwives – n/a to RDaSH))	30.26% (n=23)	32.66% (n=32)
Allied Health Professionals	13.16% (n=10)	10.20% (n=10)
Cleaning/ Maintenance/ catering/ ancillary staff/ Admin and clerical	34.21% (n=26)	27.55% (n=27)
Healthcare assistants	5.26% (n=4)	4.08% (n=4)
Doctors	1.32% (n=1)	1.02% (n=1)
Corporate Service Staff	2.63% (n=2)	4.08% (n=4)
Public Health	n/a	n/a
Board Members	0	0
Dentists	n/a	n/a
Commissioning	n/a	n/a
Ambulances	n/a	n/a
Pharmacists	0	0
Anon/not provided	10.53% (n=8)	15.31% (n=15)
Students	0	0
Additional Clinical Services	0	0
Other (includes HV, Union Reps N/A)	2.63% (n=2)	5.10% (n=5)

What this means at RDaSH - Table 5 above provides a breakdown per staff group in terms of 'speaking up' to the Speak to the Guardian. The nurses in the organisation continue to utilise the route of speaking up to the guardian this professional group nationally has maintained the lead in raising concerns through the guardian. The category listed as 'other' includes role such as health visitors and union representatives.

We still have lower than average 'speak up' rates for medical staff. Therefore, there has been an increased focus by the FTSU Guardian to ensure all medical staff are aware of 'speak up' routes. The recruitment of a FTSU Champion within the medical workforce has helped. Over the last 6 months the Guardian has attend various doctor forums and linking in with Dr Babur Yusufi (Guardian of Safe Working Hours GoSWH) for encouraging a safe speaking up culture for the doctors. The Guardian has also attended informal Junior Dr forums in order to further promote speaking up and will be asking for volunteers to complete the FTSU champions training.

Section 2 - Patient and Worker Safety/ Experience Issues

Table 6 below reflects the RDaSH position in relation to concerns raised with regard to patient safety, bullying and harassment whether these were anonymous and also concerns of perceived detriment.

Table 7 shows the comparison with RDaSH and other neighbouring Trusts.

Table 6 – National Comparisons concerning "speak up" theme and experience

Theme or experience	RDaSH 2023/2024 76 concerns (as at 24/11/23)	RDaSH 2023-2024 98 concerns (as at 26/03/2024)
% of Patient Safety Concerns	14	24
% of Bullying / Harassment Concerns	24	28
% reported anonymously	8	14
% reported perceived disadvantageous and/or demeaning treatment (detriment)	1	1

Bullying and harassment continue to make the largest portion of concerns raised alongside concerns with elements of patient safety. Any concerns with elements of patient safety are raised to the SLT in the respective Care group alongside FTSU panel for further factfinding/investigation, with assurance given to Guardian of next steps. Concerns raised with elements of bulling and harassment are again raised to the SLT in the area/CG raised in the concern with the support of FTSU panel/OD.

Table 7: FTSU Guardian Report Q1-Q3 2023/24 – comparison with neighbouring Trusts

Trusts	Number of concerns brought to FTSUGs	anon	patient safety/ quality	worker safety or wellbeing	bullying or harassment	inappropriate attitudes or behaviours	disadvantageous and/or demeaning treatment (detriment) as a result of speaking up
RDaSH	**78**	**8**	**15**	**30**	**25**	**33**	**1**
DBHT*	**60**	**0**	**39**	**53**	**8**	**13**	**2**
NLAG	**248**	**20**	**43**	**42**	**33**	**127**	**3**
RFT*	**7**	**2**	**0**	**0**	**6**	**4**	**0**
SCH	**93**	**0**	**23**	**20**	**16**	**32**	**0**
SH&SC	**89**	**2**	**16**	**12**	**0**	**20**	**6**
STH	**55**	**8**	**18**	**21**	**15**	**2**	**8**
Humber	**23**	**0**	**23**	**18**	**8**	**0**	**0**
LPT	**64**	**0**	**16**	**28**	**10**	**10**	**1**

What this means at RDaSH – Each of the concerns raised in the Trust have been discussed and progressed at a team level, with learning then explored at an organisational level, triangulating learning

and data through Care Group, Directorate and POD and Safety and Quality Meetings, identifying opportunities to learn and improve.

We continue to explore options to encourage speaking up openly and work with our people, so they feel confident in speaking up without fear of detriment and to promote open cultures within teams and the organisation. We continue to share learning and improvement that has resulted from speaking up to show others that the process is there to support them and to improve patient care.

Section 3 - Action taken to improve FTSU culture

All our people can access the new FTSU e-learning on the Electronic Staff Record (ESR), The first module – Speak Up – is for all workers, second module - Listen Up is for managers and anyone that supervises people this module focuses on listening and understanding the barriers to speaking up. The final module, Follow Up is now available, it is for senior leaders to support the of Freedom to Speak Up as part of the strategic vision for organisations and system. We would like to explore this module with the Board of Directors as part of their development alongside completion of the reflective planning tool for FTSU.

The FTSU Guardian is actively engaging with the organisation and is arranging visits to all our champions in their workplace environments to build connectivity and engagement.

Currently we have 58 FTSU champions trained champions and 38 colleagues who have expressed an interest in becoming a FTSU champion. There has been particular focus on increasing the champions within inpatient settings given the concerns arising from the panorama/dispatches documentaries in 2022 as well the recent shocking revelation from the Lucy Letby case. Once the new champions have been trained, they will be invited to our regular Champions meetings, their contact information will be advertised on leaflets/posters and promotional materials. Regular and targeted communications will be channelled through Daily Briefings, Intranet, on-line and in-person events and display boards across the organisation.

The NGO have recently changed their formal champion training package and we are in the process of updating our training in line with this. This new training has been rolled out face to face to all new champions along with a virtual refresher for our current champions.

Targeted FTSU Engagement and Induction

Work has continued to take place regarding increasing FTSU communication and enhanced induction for new starters including the international nurses. Information on speaking up is shared in trust publications.

The Guardian continues to deliver induction engagement sessions to the IEW's speaking about the importance of the FTSU agenda.

Schwartz Rounds/Team Time

The rounds have been facilitated to support individuals to tell their stories and they promote "speaking up" about experiences in the health care sector. There is a high demand for bespoke Schwartz Rounds in clinical areas.

The guardian is in the process of completing the Schwartz round facilitator training and is now able to deliver Schwartz round as a facilitator throughout the trust. (the training should be completed by 2024)

Leadership Support Circles now known as Cultivating Compassion Circles (3Cs)

These are interactive 1-hour sessions that occur monthly via teams comprising of 10 Themes - where we can share and thrive together. Safe spaces where people of all levels share their experiences and are heard. The Guardian takes a collaborative role in delivering the sessions alongside colleagues from organisational development.

‘Speaking Up” and Staff Diversity Networks

The RDaSH FTSU Guardian continues to attend virtual meetings for all the staff networks, being visible and creating safe psychological spaces for colleagues to discuss their concerns. The role of FTSU Guardian is seen as a vital mechanism to ensure that people can continue to care for patients safely and to support staff wellbeing.

Safety Culture at RDaSH

Anti-racism Alliance - continues the journey towards the organisation becoming an anti-racism organisation as Promise 26 of the clinical strategy. Anti-racism work at RDaSH continues to be delivered in a systematic and structured way following the Anti-racism framework as advocated by NHS England and the Northwest Framework; and aligns with the REaCH inclusion network. The Anti-racism alliance meets bi-monthly and has the CEO as the executive sponsor who is overseeing and guiding on this work. It has attendance and representation from operational colleagues to senior managers either with or without lived experience. We have developed an action plan that has been shared within the Alliance and the work allocated to fully implement the framework. The aim is that we eradicate racism and discrimination from our organisation and work towards requesting recognition and accreditation from the North-West BAME Assembly.

Widening Cultures via Communities of FTSU practice

Our RDaSH FTSU approach is to ensure that we are fully linked into several networks to benefit from a collective approach to ‘speaking up’. The FTSU Guardian attends regional FTSU Guardian meetings and accesses peer support regularly that has been put in place. The National Guardian’s office has psychological sessions and webinars to support guardians, it is recognised that FTSU Guardians need support to continue to be fully effective within their organisational role.

Visibility of the Guardian

The guardian has focused on increasing visibility through the organisation and visits each CG once every 4-6 weeks to help develop trust within the staff group and to help ‘spread the word’ of what FTSU does. Some other action the guardian has taken are below:

- Present at each staff diversity network
- Present in all peer reviews
- Expanded champion’s network
- Shadowing opportunities with the Guardian
- Substantive FTSU Guardian now in place from Feb 2024
- Confidentiality is maintained throughout the process with oversight from the guardian.
- Confidentiality is discussed withy champion in the FTSU Champions network.
- Peer network with other guardians in the region

Freedom to speak up month October 2023- (breaking barriers)

During freedom to speak up month for the month of October 2023, the guardian based himself in a different locality each week. One day was a stand where there where freebies available for staff and the guardian made himself available to discuss with staff the importance of speaking up. The other day was a Hub where staff can approach the guardian to discuss any concerns, they have regarding the places they work in.

Also trust comms was sent every week for the month of October with senior leaders throughout the organisation promoting the importance and value of speaking up.

Section 4 - Learning and Improvement

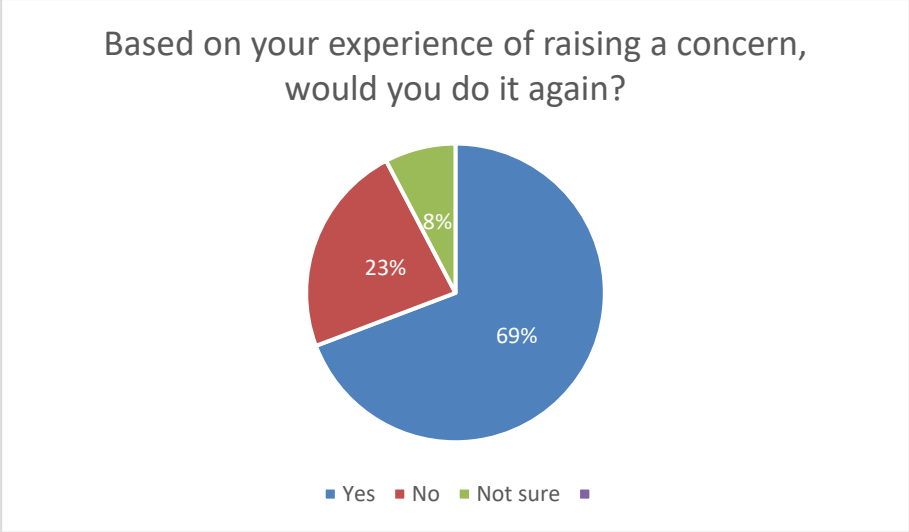
There are 23 concerns open at present (this includes 2* cases where staff spoke up on the same issue). all other concerns have been closed. Below is a list concerning high level detail of learning points related to the concerns raised within 2023/24.

- Civility and respect issues, Civility framework and behavioural charter to tackle some of these issues is being explored.
- Recruitment of more FTSU champions- this has been addressed and training has been delivered to the new volunteers.
- Anti Racism Alliance
- Amendments to social media policy within the trust.
- Implementation of the Standard Operating Procedure for Onboarding and Supporting Internationally Educated Workforce.
- Guardian attending all Peer reviews in inpatient setting.
- Patient safety experiences
- Staff fatigue and staff shortage- worker experience
- Team Dynamics – potential disruption of teams working together post pandemic, remote working, pressure, and fatigue.
- Concern around safe staffing numbers
- Concerns around safe staffing numbers in inpatient's setting.
- Implementation of FTSU mangers form to formalise timescales for resolution of concerns and how learning will be imbedded within the service.
- FTSU policy review in line with recommendation from NGO currently out for consultation with a view to publish early April 2024.

RDaSH Feedback

Feedback is obtained from all who speak up, except for those who speak up anonymously. The feedback that has been provided by colleagues and learners who have spoken up has been predominantly positive and corresponds with national comparators. Freedom to Speak Up Guardians ask those they support whether, given their experience, they would speak up again. In most concerns where feedback was provided, people answered 'Yes', however this was lower than previous years. Work has been undertaken by the current guardian to understand why the individuals responding to the survey had this experience of FTSU process. After discussing this with the people in question this had been due to the absence of feedback from a historical FTSU concern, which has now been addressed within the care group.

At RDaSH all people who spoke up confidentially or declared their name are given to option to provide feedback.



Reasons for not wanting to access FTSU seem to relate to a lack of understand of the process and achievable outcomes when the concern is ready to be closed. The guardian continues to look at ways of making the achievable outcomes clearer at the beginning of the process which should help to address this.

Has the cultural work been effective at RDaSH?

The focus upon FTSU cultural work appears to have been effective in both supporting the development of a Trust wide 'speak up' culture and increasing the number of concerns raised as evidenced in section 1 of this paper. The discussions concerning FTSU are also widening in terms of the Trust introduction of RJLC principles and practices. During 2023/24, the Guardian alongside colleagues in the OD Team have run development sessions on workplace Civility and Respect which underpins our workplace culture.

Section 5 – Recommendations

Within this paper details have been provided in terms of FTSU approaches, developments and concerns raised within RDaSH since the previous report in April 2023. Internal and external data is summarised and presented to Board of Directors to help review Freedom to Speak Up arrangements. It also highlights actions taken regarding Concern management monitoring arrangements as well as activities to promote leadership visibility and encourages a systemic approach to raising concerns.

Within the next 6-12 months recommendations are made that the following work will be conducted to enhance FTSU approaches at RDaSH:

1. FTSU concerns are discussed alongside other patient safety and staff wellbeing information to triangulate data provide preventative interventions and promote organisational learning. FTSU should be discussed in the safety huddles/team meeting throughout the clinical and corporate settings alongside and in conjunction with RJLC.

2. Leaders and individuals, who manage 'speak up' concerns to ensure that the FTSU is sighted on the actions and learning from these concerns.

3. Ensure that all team and areas know how and who to contact for support or advice in terms of FTSU matters, please contact James Hatfield (FTSU Guardian).

4. Ensure instances where individuals may have suffered detriment for speaking up are promptly and fairly investigated and acted on. Work continues to ensure senior leaders are clear that detriment will not be accepted, and that are clear processes for identifying and addressing when FTSU concern results in detriment.

5. Given the current climate with regards to the recent panorama and channel 4 documentaries, we need to sense check front line worker understanding of *Civility and Respect* with FTSU linking into this when trust values are not be adhered to. The OD team would be an active support from team development in this area.

6. Work continues to consider the knowledge gap with regards to a lack of specific training and awareness given to ward managers/team leaders.

7. SBAR concerning MAST FTSU to be provided to the education and learning group – for decision regarding the 'speak up listen up and follow up' training.

8. Half Day learning session to be provided in Q2 2024/25 open to all staff. Differing themes in the FTSU agenda will be covered.

9. Board session to be conducted, considering current FTSU themes and trends and this reflective tool and action plan.

10. Quarterly meetings to be reinstated with CEO / NED responsible for FTSU and Director responsible for FTSU.

11. Five members of SLT to be provided with additional training to provide a business continuity plan in terms of Guardian cover regarding leave.

APPENDIX 1

Headlines 2022/23

TOTAL CASES

25,382 cases
were raised with
Freedom to Speak Up Guardians
in 2022/23

The highest number of cases recorded - 25% increase from 2021/22.

QUARTER 3 HAD THE LARGEST AMOUNT OF CASES

Quarter 3 (Oct-Dec 2022) had the highest number of cases raised with Freedom to Speak Up Guardians in a single quarter (6,947), a record number of cases.

This may be as a result of the awareness raising which takes place during Speak Up Month every October.

SOURCES OF CASES

Cases raised with Freedom to Speak Up Guardians in NHS Trusts (23,392) accounted for 92.2% of cases in 2022/23.

A further 1,990 cases (7.8%) were raised in other organisation types.

PROFESSIONAL GROUPS

Workers from a range of professional groups spoke up to Freedom to Speak Up Guardians.

Nurses and midwives accounted for the biggest portion (29%) of cases raised.

ANONYMOUS CASES

The percentage of cases which were raised anonymously has fallen to ten percent (9.3%).

This continues the downward trajectory from 2017, when 17.7% of cases were raised anonymously.

BULLYING AND HARRASSMENT

22 % of cases reported included an element of bullying or harassment.

A 10-percentage point fall compared to 2021/22 - this is at least in part due to cases being reported against the new category of 'inappropriate attitudes and behaviours'

WORKER SAFETY AND WELLBEING

One in every four cases raised (27.4%) involved an element of worker safety or wellbeing.

PATIENT SAFETY AND QUALITY

19.3% of cases raised included an element of patient safety/quality, up from 18.8% in 2021/22.

INAPPROPRIATE BEHAVIOURS

30% of cases involved an element of inappropriate behaviours and attitudes.

The most reported theme in 2022/23.

DETRIMENT

Detriment for speaking up was indicated in 3.9% of cases.

This is down from 4.3% in 2021/22 but higher than 2019/20 and 2020/21 levels.

FEEDBACK

Over four-fifths (82.8%) of those who gave feedback said they would speak up again.

APPENDIX 2

45%

of respondents said that there had been an improvement in the speaking up culture in the healthcare sector over the last 12 months. Over a quarter (26%) said the speak up culture in healthcare had deteriorated. This was a sharp decline compared to previous years when most respondents consistently reported improvements in the speaking up culture in the healthcare sector (73% 2021, 80% 2020).

74%

almost three-quarters of respondents said that senior leaders supported workers to speak up, a three-percentage point decrease compared to the results of the previous survey (71%, 2021).

59%

of respondents said the speaking up culture in their organisation had improved over the last 12 months. Twelve per cent said it had deteriorated. In comparison, three quarters of respondents in the previous survey said the culture in their organisation had improved in the preceding 12 months

51%

over half of respondents said managers supported workers to speak up. Fifteen per cent disagreed.

69%

of respondents said that speaking up was used in their organisation to identify learning and make improvements. Sixty-seven per cent agreed that there was assurance about the speaking up culture and arrangements, and a plan to improve it