HEALTH SELECT COMMISSION
17th March, 2016

Present:- Councillor Sansome (in the Chair); Councillors Ahmed, Burton, Elliot, Fleming, Godfrey, Hunter, Khan, McNeely and John Turner.

Apologies for absence were received from Councillors Mallinder, Parker, Rose, M. Vines, Victoria Farnsworth (Speak-up) and Robert Parkin (Speak-up).

78. DECLARATIONS OF INTEREST

Councillor Fleming declared a personal interest as he was an employee of the Sheffield Teaching Hospital Foundation Trust.

79. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no members of the public and press present at the meeting.

80. COMMUNICATIONS

A. Information Pack
Health and Social Care Integration
The discussion paper was important in context of the Select Commission's brief.

BCF Q3 Return
The cover report contained key information. The return template to the NHS England could be found at

(http://moderngov.rotherham.gov.uk/documents/s104800/BCF%20Appendix%20A%20%20BCF%20Quarterly%20Data%20Collection%20Template%20Q3%2015-16%20FINAL.pdf)

Care Quality Commission Guidance Documents
Any comments to be forwarded to Janet Spurling, Scrutiny Officer.

B. General Practice
Contracts
Further to Minute No. 41 of the meeting held on 22nd October, 2015 (Interim GP Strategy), it was noted that the Gateway procurement had concluded. The Gateway CIC had retained the contract so there would be no changes.

Chantry Bridge patients had been dispersed to other practices. Only one patient had raised an issue with the Clinical Commissioning Group who had then worked with the patient to get them into a practice they were happy with. There were still some patients who had not yet registered with another practice but the CCG were confident that this was primarily because they had left the area.

Treeton GP Practice
The Clinical Commissioning Group had met with the developers regarding a new medical centre on the Waverley site. They were keen to explore options for the community in that area but were mindful that Treeton was at capacity and work should progress as soon as possible. The developers were meeting regularly with the Planning Service and, subject to planning permission, the CCG were looking to an opening at the end of 2017.

YAS Quality Account Feedback
Members were thanked for submitting their comments with a reminder to those who had not done so yet of the 18th March deadline.

Rotherham Clinical Commissioning Plan
The deadline for comments was Friday, 18th March.

Adult and Older People Mental Health Transformation
It was hoped that an update would be submitted to the April Select Commission meeting.

Joint Health and Overview Scrutiny Committee Meeting held on 26th February, 2016
The powerpoints were available from the meeting which provided good background information for the national picture. The information contained therein included:-

- NHS England Specialised Commissioning and National Service Reviews
- Regional Strategic Overview including delivering the Five Year Forward View and Sustainability and Transformation Plans
- Care Quality Commission – their approach to inspection and regulation and how they work with Overview and Scrutiny Committees
- Further work around delayed transfers of care (DTOC) could be included in the work programme for the Joint Committee

81. MINUTES OF THE PREVIOUS MEETING

Resolved:- That, subject to the following clerical corrections, the minutes of the previous meeting of the Health Select Commission held on 21st January, 2016, be agreed as a correct record:-

Minute No. 72 (Overview of Public Health/Spend the Public Health Grant in Rotherham)

Health Challenges in Rotherham – should read “Rotherham women 81.4 years”

and Value of the Ringfenced Grant – should read “2014/15 - £14.175M”.

Arising from Minute No. 72 (Overview of Public Health/Spend the Public Health Grant in Rotherham), attention was drawn to the fact that the figures did not add up to 100%.

82. ROTHERHAM FOUNDATION TRUST QUALITY ACCOUNT

Tracey McErlain-Burns, Chief Nurse, gave the following powerpoint presentation:-

Quality Ambitions 2014-16

- SAFE Mortality – Reduction in HSMR (Hospital Standardised Mortality Ratio) year on year
- SAFE Achieve 96% Harm Free Care (HFC) with zero avoidable grade 2-4 pressure ulcers and zero avoidable falls with harm
- CARING & RELIABLE Achieve improvements in all Friends and Family responses
- RELIABLE Achieve all national waiting times targets i.e. 18 weeks, cancer and A&E

Quality Improvements 2015/16

- 100% of unpredicted deaths will be subject to review
- From a baseline of 120 we will reduce the number of patients with a LOS>14/7 (length of stay greater than 14 days)
- Improved reporting of the deteriorating patients
- Reduce noise at night
- Increase the number of colleagues trained in Dementia care and reduce complaints
- Improve complaints response times
- Meet stroke targets

So how have we done?
Mortality

- Rolling 12 months HSMR
  December 2014 = 99.28
  November 2015 = 108.06
  (March 2015 – 112.48)
- SHMI (Standardised Hospital Mortality Index) July 2014 to June 2015 111.64

Harm Free Care

- Achieve minimum 96% Harm Free Care with the following percentage reduction on the 2014/15 baseline (No. Trending at 94.85%; a 0.5% improvement on the previous year):-
- 70% reduction in avoidable pressure ulcers grade 2-4 (yes – 74% achieved)
- 50% reduction in avoidable falls with significant harm (yes – 57% achieved)

Family and Friends Test (FFT)

- Achieve and maintain a minimum 95% positive (FFT) score – in-patients (yes – 97% achieved)
- Achieve and maintain a minimum 86% positive FFT score – A&E (yes 88% achieved)
- Achieve a 40% FFT response rate – in-patient areas (yes 41% achieved)

4 Hour Access – National Comparison

Period	TRFT Performance	TRFT Rank (of 140)	England Avg (Type 1)	No of Trusts >95% (Type 1)
April	93.3%	53	89.8%	31
May	97.3%	9	92.5%	45
June	97.1%	16	91.5%	53
Q1	95.7%	23	91.1%	44
July	93.7%	73	92.5%	55
August	88.6%	113	91.5%	44
September	93.9%	46	90.1%	34
Q2	92.1%	79	91.45	43
October	92.5%	44	88.6%	21
November	93.7%	29	87.1%	14
December	85.5%	82	86.6%	14
Q3	90.5%	58	87.4%	12

Other Improvement Priorities

- 100% of unpredicted death reviews – yes
- Reporting of the deteriorating patient – yes
- Noise at night - ?
- Dementia training – yes (61% of TRFT colleagues have had first level dementia training)
- Complaints performance – no
- Stroke targets – yes (improved proportion with AF anti-coagulated on discharge; proportion admitted directly to Stroke Unit and spending 90% of their time on the Stroke Unit; proportion scanned within an hour. Business case for allied health professional ESD team supported)

Other items to be covered in the Quality Account/Report

- Staff and patient survey results
- Listening into Action work
- Environmental improvements
- Community transformation
- Progression from the CQC action plan to a Quality Improvement Plan
- Serious incidents and Never Events
- Data quality
- Workforce

Discussion ensued with the following issues raised/clarified:-

- 4 hour access - performance had deteriorated from Q1 to Q3 and was an area of concern for the Trust

- There were a number of reasons for not meeting the A&E national target the majority of which had related to workforce matters within the Emergency Department and more recently delays in waiting for access to beds. There had been recruitment of consultants, middle grade Doctors and nursing colleagues and the use of a number of locums in the Emergency Department

- The Trust Board received an Operational Performance report and Integrated Performance report (available on the Trust's website) which provided the detail about how long patients were waiting; it did not give a number for those waiting but an indication could be provided outside of the meeting

- Those patients whose hospital stays were longer than 14 days were often elderly who were admitted during the Winter period and took longer to recover from their conditions. There was the chance that some, as it got nearer to their expected discharge date, might get a hospital acquired pneumonia due to their long length stay, or not being able to achieve a discharge plan for that patient which required multi-agency responses

- At the time of the 2015/16 Quality Account, a baseline had been set of 120 patients with a long length of stay. As of August, 2015, the Hospital had been below that baseline. An ideal target of 70 had been set which enabled the Trust to manage its bed base effectively. There had been no reduction in the number of beds across the particular time period; the figure of 70 had been calculated on the reduction of bed places previously. The reduction had been achieved with no more than 70 patients in hospital with a long length of stay and it had been planned to open beds over the winter period. That Ward remained open at the moment

- The steady increase in November had been a combination of factors. There had been pressure on A&E and work was taking place with colleagues to change the systems of working and in doing so recognised that more work was required to improve the internal systems particularly in recognising what the expected day of discharge was and how that was communicated to other agencies

- When talking about planning a patient discharge, the Hospital would often refer to the EDD (Expected Date of Discharge) which was one measure when the patient was considered, usually by the medical clinician, as being medically fit for discharge. What the Trust was trying to do currently was identify a date at which point a patient was:

(a) considered medically fit for discharge
(b) socially ready for discharge and may well include readiness of other partners to support the patient and family, and
(c) therapeutically ready for discharge particularly if Physiotherapy and Occupational Therapy colleagues might be involved

- The Trust did not have any trained psychologists; the only areas where there was some active psychological intervention was within some of the Cancer pathways. However, a number of the community-based colleagues had extensive communication skill training which took account of some psychological therapies but no training in psychological therapy techniques

- The Trust had the benefit of a Community Unit on the Hospital site should a patient require ongoing rehabilitation of a non-acute nature. There was also access to intermediate care beds through work with Social Care colleagues. If the Trust had particular pressures and had a number of patients that no longer needed to be in hospital, then work would take place with Social Care and the Clinical Commissioning Group for spot purchase where a bed was purchased for a period of time in an alternative but suitable accommodation for the patient. This would be discussed with the patient's family. If families strongly disagreed with the proposal it may lead to a slightly longer delay in that patient's transfer

- Internally the Trust's target was to have no more than 20 patients in hospital who had a long length of stay and were medically fit for discharge. The presentation showed that the Trust had been having around 30-40 patients in hospital who were medically fit for discharge with an average length of stay beyond being medically fit of about 10 days. However, in the last couple of months there had been no significant increase in those numbers

- A range of mechanisms had been used to gain the patient's opinion. Trust Governors held surgeries and had spoken to many patients, families and visitors to the Hospital. The report was submitted to the Council of Governors with a management response. Further information about the Governors surgeries would be forwarded

- Friends and Family Test – still difficult to obtain responses in the Emergency Department despite trying various means. The dip in response rates and scores in C&F services was in relation to the School Nursing Service but had improved since the survey was changed from a four point to a six point scale.

- The Trust worked with a company, Dr. Foster, and through the use of Dr. Foster data sets were able to analyse mortality by diagnosis, by weekend, by day of the week and also looked at crude mortality and compared its mortality rates with other Trusts. There was a depth of data which the Quality Alerts and Mortality Group analysed on a

monthly basis and more recently the Medical Director had presented a report to the Board which was available on the Trust's website

- The Health Care Support Workers in the community were working on pressure ulcer avoidance

- The Trust measured data outliers on a daily basis by speciality; the Executive Team knew how many the Trust had. Currently there were approximately 20 patients who had been moved from 1 area to another

- There were currently 29 consultant vacancies within the Trust, many of which were being filled by locum colleagues. 5 consultants had successfully been recruited recently. The newly recruited Head of Medical Workforce would assist with the plans to make the Trust attractive to new recruitment. In some areas there were particular national shortages and district general hospitals of Rotherham's size would always struggle to compete when there was a large teaching hospital not too far away

- There were currently approximately 30 registered nursing vacancies, 22 at Band 6, and 8 at Band 5. The overseas recruitment programme had been suspended with the Trust investing in the development of the colleagues already recruited

- Additional Health Care Support Workers had been recruited together with a further 20 apprentices. There was a workforce improvement programme taking place but inevitably the use of locum and agency colleagues did not give the sense of loyalty to the organisation as that of its own workforce

- Universities still had more potential nurses apply for places than there were training places available. It was not yet understood what the impact of the changed bursary system for potential nursing students would be

- Currently there were 140 student nurses on placement at the Trust together with 50 allied professional students. Previously placement students had reported a positive experience and Tracey actively engaged with them from the beginning to help them see the benefits of working at Rotherham Hospital

- Agency nurses were currently still used where there were vacancies and, where there was long term sickness combined in a particular area with perhaps maternity leave. The Trust was currently investing in its own workforce even if that meant the opportunity to recruit over its establishment as it gave the benefit of continuity of care for the patient, commitment from a substantive colleague and a reduction in the financial burden of using agencies

- The annual staff survey changed slightly each year. The Trust had the option to survey all colleagues or only a sample of 850. Last year it had chosen to sample all colleagues and received a mid-40% response rate. It included staff morale in a number of different ways including support for line manager, whether the individual was considering leaving the Trust, whether they had reported an incident and whether they felt they had received feedback etc.

- At the moment data quality with regard to the length of time it took before a Ward requested medication for a patient to be discharged was received was not formally reported
  Following the meeting the information below was provided for HSC
  The target was to turn the script around in under 120 minutes. The average turnaround once the prescription arrived in pharmacy was 98 minutes. This was monitored monthly and reported to the division of support services.

- There were a number of things that enabled colleagues to progress their career. There were opportunities for Health Care Support Workers to become Registered Nurses by going to university, however, the numbers were very small. There may be an opportunity for Health Care Support Workers with regard to assistant practitioner roles

- The intent, whether medical or nursing colleagues, was to recruit the Trust's own workforce and reduce agency costs. It was becoming increasingly difficult to attract some agencies as a consequence of the implementation in agency caps and therefore the reduction of the hourly rate that was paid to individuals. The Trust projected that it would continue to recruit nursing colleagues, vdrive out the use of agency combined with increasing its internal bank. Similarly for medical colleagues, the strategy was again to recruit substantively and avoid the need for agency colleagues. It could be difficult to recruit Doctors in certain areas due to national shortages and, therefore, anticipated that there would still be some reliance on agency and locum doctors. In terms of working together and savings, as a Working Together Partnership, the Trust would be looking to circa £30M savings through procurement given the amount of budget the Working Together Partnership had

- The Trust currently did not utilise self-medication in the Hospital. The majority of patients who were admitted to Hospital had their medication administered by nursing colleagues. A few patients would self-medicate whilst in hospital but it was a question as to whether there should be an increasing opportunity to self-medicate. The benefit of a patient being involved in self-medication was that when they went home they knew more about their medication. However, not many patients would be able to self-medicate when they went into hospital. Work was taking place with the new Chief Pharmacist to try and have more technical pharmacy input to help patients understand

their medications for when they returned home. There were some instances when patients were ready to go home but were waiting for their take home drugs to come back to the Ward. This could be a cause for concern

- There were some patients who had sufficient medication at home who had had no changes to their medication and would have been able leave the hospital sooner. The new Chief Pharmacist, Medical Director and Chief Nurse were currently putting together an improvement plan for medicines management. It would focus not only on medicine safety whilst in hospital but also increasing patient understanding of medication when in hospital and shortening the period they waited for medication once told they could go home. The aim would be to seek to try and achieve increased numbers of patients having an understanding of their expected date of discharge sooner in their hospital stay and, once clinicians had agreed with the patient and family the date to work towards, an obligation to prepare a prescription that could be taken to the Ward before the patient was in the position of having a long wait

Resolved:- (1) That the information presented be noted.

(2) That the draft Quality Account document be submitted to members of the Health Select Commission for their consideration.

(3) That the Select Commission provide feedback to the Foundation Trust in accordance with their timescales.

83. UPDATE ON BETTER CARE FUND

Jon Tomlinson, Interim Assistant Director Commissioning, gave the following update on the Better Care Fund:-

Background

- The Select Committee has previously received updates about progress with the Better Care Fund (BCF)
- Rotherham has successfully established robust governance and submitted returns to NHS England in a timely manner
- The BCF remains a key vehicle for integration between the NHS and local authorities
- The original BCF plan was developed around 2 years ago
- NHS England recommend that partners review their plans to ensure that progress is maintained and that funds are effectively targeting the right areas
- An initial review has been carried out on our plan and the outcomes are as follows

BCF Review

- The original BCF plan had 72 lines of funding and 15 themes
- The revised plan has 33 lines of funding with 6 broad themes
- The 6 themes cover:-
  Mental Health
  Rehab/Re-ablement and Intermediate Care
  Social Care Purchasing
  Case Management and Integrated Care Planning
  Supporting Carers
  BCF Infrastructure
- Each theme has then been rag rated in relation to strategic relevance, service specification in place, performance framework in place and are there any performance issues
- There are then recommendations about each service within the theme
- The schedule of reviews have been programmed and will take place between now and October dependent on priority
- These reviews cover 18 BCF schemes and where there are funding or performance issues or where there are concerns regarding strategic relevance

Other BCF Development

- A joint visioning event has taken place between the NHS and RMBC to further strengthen work around integration
- Our latest submission confirmed that national targets are being met
- We continue to perform well against a number of the metrics
- The BCF has increased by £1.3M from £23.2M to £24.5M
- Additional funding will be invested in Community Services
- New integration measures were introduced for the Q3 submission
- Further planning guidance has been received during February and March and officers are responding to it
- A BCF Service Directory is almost finalised

Discussion ensued with the following issues raised/clarified:-

- Currently in the Assurance period for the 2016/17 plan. Guidance had been received regarding what was required to meet assurance in terms of the plan and it was currently being written. The second stage of the Assurance process would be updated shortly with the final plan being submitted to the Health and Wellbeing Board for sign off on 20th April and NHS England on 25th April

- In order to achieve Assurance, it had to been ensured that the Plan was responding to the Key Lines of Enquiry. It was a fairly extensive process at the moment and was being reviewed through the BCF Executive by senior managers of both RCCG and RMBC to ensure the budget submitted in April responded effectively which would gain Assurance. The plan would be assessed and there would be a decision taken as to whether or not it was in full compliance and doing the right things to meet the needs of the citizens in the area. If not,

some support would be offered. In terms of reviewing and assurance of the plan, the Local Government Association, Monitor and others took part in the assurance and there was mediation across all the plans to ensure they were acceptable

- The needs of carers, whether adults or young people, needed to be responded to. It was the plan's ambition to ensure it responded to all carers and supported them

- The Health and Wellbeing Board was responsible for the governance of the plan. One of the Board's key responsibilities was to ensure it was an effective plan and whether it was an effective and integrated service. There was then a governance system with involvement of Board and senior managers as well as a strategy group, executive group and an operational group. The operational group included all the managers who were involved in delivering the projects/schemes and services. It was proposed that the strategy group develop into a programme board to ensure that the integration plans were progressing effectively. Each group had its own terms of reference

- There was multi-agency support in terms of supporting young carers as well as a multi-disciplinary response. There was a joint post in CYPS and the CCG for commissioning services

- There was much more detailed information available for the 6 BCF themes

- Generally speaking all the Indicators were performing pretty well

- All the organisations in the care system welcomed feedback to improve where partners needed to be and had to be prepared to decommission as well as commission if something was not effective

- Much of the Care Act talked about early intervention and preventative services. Every Rotherham pound had to be spent effectively consideration had to be given as to whether some of the things being delivered were effective and did they need to be changed

- It was difficult to give a timeline as to when data sharing across IT systems of health partners and social care would include Mental Health. The data sharing that was described in terms of the BCF at the moment was with regard to a particular cohort of citizens. In terms of extending it, consideration would be given as to how the work had moved forward but would look to using the NHS number as the main indicator

- The locality pilot was very much part of visioning events. The original visioning event had been held in early December at which time the locality discussions were already taking place. The visioning events were agreeing a high level set of outcomes to achieve across the system of which part of would be good locality working

- The 7 day Service was progressing well and being monitored through the BCF Executive. The Social Care Team that responded to requests for assessment was in place and had been since December.

Resolved:- (1) That the presentation be noted.

(2) That the Chair liaise with Adult Social Care with regard to the scheduling of future agenda items in the 2016/17 work programme.

84. ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST QUALITY ACCOUNT

Karen Cvijetic, Head of Quality and Patient Engagement, gave the following powerpoint presentation:-

Quality Report
- Nationally mandated
- 2015/16 was the eighth quality report

Care Quality Commission (CQC) Ratings (September 2015)
- Overall rating – requires improvement
- Safe – requires improvement
- Effective – requires improvement
- Caring – good
- Responsive – good
- Well-led – good

What the CQC said we do well
- Learning Disability Services
  Solar Centre – commended by patients and carers
  88 Travis Gardens – outstanding for caring
- Adult Mental Health Services
  Mental Health Crisis Teams – rated overall by CQC as Outstanding
  Mulberry House – introduction of the 'Perfect Week'
  Doncaster Perinatal Service
  Rotherham dedicated service for deaf patients with mental health problems
- Children and Young Peoples' Mental Health Services
  Safeguarding Advisor in post and training at a high level across all services
  Out of hours duty system provides excellent coverage of emergency/crisis calls

Peer Support Workers assist with transition to Adult Mental Health Services

- Drug and Alcohol Services
  Peer Mentor Scheme developed including training packages to provide service users with the skills and knowledge to become Peer Mentors
  Peer Mentors from New Beginnings worked across the services in Doncaster and three had progressed into paid employment
- Older People's Mental Health Services
  Community-based services for Older People rated as Outstanding for Caring
  Young Onset Dementia Day Care offering carer respite and patient engagement
  Male Carers Support Group for patients with Huntingdon's Disease
  Cognitive Stimulation Programme – support patients with cognitive functioning
  Kings Fund advice and guidance to make Wards Dementia Friendly

Our Approach and Response

- September, 2015 – immediate actions were taken and action plan drafted following initial feedback from CQC
- November, 2015 – Trust Quality Improvement Plan developed following receipt of draft CQC reports
- December, 2015 – Executive Director leads identified for all quality improvement actions
- February, 2016 – Trust Quality Improvement Plan shared at Quality Summit
- March, 2016 – action plan submitted to CQC

Governance Arrangements

- Published CQC reports to the Board of Directors' meeting on 28th January, 2016
- Monthly action plan updates to Board of Directors
- Monitoring and oversight by Executive Management Team (EMT)
- Divisional action plans monitored through Trust Board of Directors' Sub-committees
- Divisional-level action plans to address local issues and share learning

Patient Safety

Quality Metric	Baseline 14/15	Aim	Q1 15/16	Q2 15/16	Q2 15/16
Patient Safety					
		Aim to Reduce Major/ Moderate Medication Errors to 0 by March 2018			
Number of Serious incidents	88		24	17	18
			2015/16 forecast: 82		
Number of Trust reported suicides/suspected suicides	21		4	5	2
			2015/16 forecast: 18		
Number of Trust reported suicides/suspected suicides expressed as a rate per 100,000 England population	0.05		0.01	0.01	0.01
			2015/16 forecast:0.01		
Number of Grade 3 pressure ulcers	29		2	0	4
			2015/16 forecast:8		
Number of Grade 4 pressure ulcers	5		0	0	0
			2015/16 forecast:0		
Number of restrictive interventions	Not reported in 14/15		417	301	345
			2015/16 forecast:1436		
Number of falls (serious incidents)	2		1	1	2
			2015/16 forecast:4		

Number of medication errors	45		8	3	Reported quarter Retro-spective
			2015/16 forecast:32		

Patient Experience

Quality Metric	Baseline 14/15	Aim	Q1 15/16	Q2 15/16	Q2 15/16
Patient Friends and Family Test					
Percentage of service users/patients who would 'be extremely likely/likely to recommend our service to friends and family if they needed similar care or treatment'	95.6% (Q4 14/15	To achieve % above national average	84.7%	87.3% (July/ Aug 2015)	88.3%
Complaints					
Number of complaints received	124	Aim to reduce by 5% (117 in 15/16)	33	24	34
			2015/16 forecast:114		
Percentage of complaints 'upheld'	17%	Reduce by 5% (16% in 15/16)	9.1%	12.5%	Reported Quarter Retro-spective
			2015/16 forecast:10.5%		
Annual Community Mental Health Survey					
Score for 'overall care received in the last 12 months' (CQC annual community mental health survey)	7.3 (about the same as other Trusts)	Aim to be 'better than other Trusts'	Annual survey results published Autumn 2015	Annual survey results published Autumn 2015	7.2
Score for 'were you involved as much as you wanted to be in agreeing what	7.9 (about the same as	Aim to be 'better than other	Annual survey results published Autumn 2015	Annual survey results published Autumn 2015	7.7

care you will receive?" (CQC annual community mental health survey)	other Trusts)	Trusts'			
Score for 'were you involved as much as you wanted to be in discussing how your care is working' (CQC annual community mental health survey)	9.1 (about the same as other Trusts)	Aim to be 'better than other Trusts'	Annual survey results published Autumn 2015	Annual survey results published Autumn 2015	7.7
Percentage of service users who responded to annual community mental health survey	26%	Aim to increase response rate above national average	Annual survey results published Autumn 2015	Annual survey results published Autumn 2015	32%

Clinical Effectiveness

Quality Metric	Baseline 14/15	Aim	Q1 15/16	Q2 15/16	Q2 15/16
CQUIN					
Percentage of CQUIN achieved in Mental Health and Learning Disability Services	96%	Aim to achieve 100%	100 %	100 %	Reported quarter retro-spective
Percentage of CQUIN achieved in Community Services	100%	Aim to achieve 100%	100 %	100 %	Reported quarter retro-spective
Percentage of CQUIN achieved in Forensic services	100%	Aim to achieve 100%	100 %	100 %	Reported quarter retro-spective
Clinical Audit					
Percentage of clinical audits rated as 'Outstanding'	To be developed in 15/16	To be developed in 15/16	22%	25%	0%

Percentage of clinical audits rated as 'Good'	To be developed in 15/16	To be developed in 15/16	33%	25%	50%

Finally

- Receive Select Commission's comments for inclusion in the Quality report – May, 2016
- Report to Board of Directors – 28th April, 2016
- Report to Council of Governors – 13th May, 2016
- Report to Monitor – 27th May, 2016
- Review by Audit Commission – April/May, 2016

Discussion ensued and the following points were raised/clarified:-

- The Learning Disability Service had received a rating of 'Inadequate'. The CQC were concerned that the staffing levels in North Lincolnshire were not safe in the community team. To mitigate that, a business case had been submitted for additional funding as the staff in that team were based on the funding received. A business case had been submitted to the North Lincolnshire CCG the outcome of which was awaited

- The issue within the Adult Mental Health Community Teams was the care record planning. Plans were in place, as could be seen through the action plan, had been rapidly escalated and hopefully resolutions put into place

- The difference between the 2 Community Health Teams – 1 was the Mental Health Services. In Doncaster Community Services were also provided e.g. End of Life Care, District Nursing, School Nursing, Health Visitors. The other was specially Mental Health Community Teams

- The Inadequate rating related to staffing issues; there had not been any comments in the CQC report that they had found clients wrongly allocated

- CQC reports do not split outcomes by locality but where it was possible, the data would be separated so as to give actions specifically for Rotherham

- As well as investigating the root causes of falls, any possible underlying cause was also investigated to ascertain if there was a medical condition. The majority of falls were by elderly people on Wards. If necessary work would take place with Acute Care colleagues to ensure medical care was taken

- The reporting of medication errors had now changed. The number of medication errors that were moderate or above where RDaSH had had involvement with the service users involved had fallen drastically. Pharmacists went onto Wards, worked across all the Community Teams, looking at how medication was prescribed, was it recorded properly etc.

- There was no trend particularly with minor medication errors. An assessment had been conducted and reported to the Clinical Governance Group. If there were any areas, the pharmacist would go to the Wards or Community Teams to address the issues

- When looking at medication errors, the organisation was trying to focus on the areas that were of higher importance; if you got the bigger areas correct it would help with the minor areas. RDaSH had focussed on the moderate severity or above where there may be harm to patients, so that improved the practice across the board including a reduced number of minor areas. Using resources more wisely to get the better impact across the organisation

- RDaSH had been involved in the Children's Looked After and Safeguarding CQC action plan and had attended monthly meetings with the CCG, Acute Care Trust and other partner organisations to implement the action plan. That action plan was hopefully being signed off shortly as being complete and RDaSH's actions as an organisation had been achieved. RDaSH was also part of the MASH where it had a member of staff sat within the team.

- RDaSH continued to hold events around CSE and awareness raising as well as Safeguarding training (adults and children), Domestic Abuse Compliance Level 1 and an e-learning package commissioned for Level 2

- There had been 2 reported suicides/suspected suicides in Quarter 3. However, it was not confirmed as yet whether they were in fact suicides as unexpected deaths were now classed as pending review until the outcome from the Coroner's Office was known

- For each serious incident, not just an unexpected death, the Trust would undertake a formal serious incident investigation and a member of staff appointed who had not had any dealings with that service user. The Trust had to report to the CCG and were monitored. The outcome was shared within the organisation and a 6 monthly learning matters bulletin available on the Trust website which included lessons learnt from a serious incident, complaints etc. by themes

- If a serious incident involved a specific clinician and the investigation identified additional training needed for that clinician that would be dealt with. There were things the Trust were going to improve e.g. care records. The Trust's Clinical Commissioning Audit Team and the

Internal Audit Service had been commissioned to undertake an audit. As a first step supervisors were to check through the 1-1s with each clinician i.e. did all the clinicians' cases have a current meaningful care record

- Delayed discharges in care were reducing. Q3 5.1% - had been 6.9% at the end of last year. Some of the reasons for the delays were due to family choice. The majority was in Older People's Mental Health Services and transferring into care homes, making sure the adaptations done at home etc. before the Service user transferred. Service users and families could choose not to accept the first place they were offered. The Trust worked closely with the Council to get the adaptations done as quickly as possible

- A number of service users and families used the Patient Advice Literacy Service (PALS). The Service talked to a person where required and linked them up with someone to help them. It was important to make sure service users and carers could access advocacy services to support them

- Each complaint received was subject to a similar process as that of serious incidents. All were investigated, all received a response from the Chief Executive and all included actions. The top themes were communication/information available so the Trust had carried out a lot of work to make sure that the information given about the service was correct. Work was needed with Service users as sometimes there were higher expectations than the Trust was able to meet and/or commissioned to deliver

- The Trust had ways of collating information including the Your Opinion Counts forms, Services worked with Service users to collect patients' stories, information was published in Learning Matters and there were regular patient stories to the Board. A number of the Services had twitter feeds so the information was collated and tailored to the needs of the population. There were Facebook pages, Services going out and collecting stories, the Health Bus and there had been a young person's event held recently in the CAMHS service

- That was a monthly publication, Trust Matters, which shared good practice both within the Trust and of the joint partnership working. That was provided to all the Trust members and available on the Trust website

Resolved: (1) That the presentation be noted.

(2) To agree a date for receiving the draft Quality Account.

(3) That the Health Select Commission submit their comments agreed by the date agreed with RDaSH

85. WORK PROGRAMME 2016/17

Janet Spurling, Scrutiny Officer, advised that consideration was required as to the 2016/17 scrutiny work programme and priorities. Cabinet, SLT and Commissioners would all have a view as well as Scrutiny Members.

The Select Commission had had a clear brief for the 2015/16 Municipal Year to scrutinise Health and Social Care Integration and work towards ensuring sustainable high quality Health and Social Care Services.

A lot had been achieved through the Better Care Fund and the Members' Working Group for Adult Health Transformation but there was still a lot of further work to take place.

Members should consider whether they wished this to continue to be a priority for the forthcoming year as the wider changes began to take place.

In 2015/16 the Select Commission had also:-

- Taken a more detailed approach with sub-groups on the Quality Accounts
- Been part of the consultation on the Clinical Commissioning Group's plan as well as the refresh of the Health and Wellbeing Strategy and Members might wish to ensure the action plans for the Strategy were being implemented next year
- Scrutinised progress on the Interim GP strategy

Mental Health had clearly been identified as a priority in the past for the Commission and ongoing transformation both for adults and older people; CAMHS could be included next year.

Sub-regional scrutiny of the NHS Commissioners Working Together initiative was also being developed

An e-mail would be sent to all the Select Commission Members with suggestions for the 2016/17 work programme and requesting further ideas.

Resolved:- That Health Select Commission Members give further consideration to the 2016/17 work programme and pass any suggestions to the Chair and Scrutiny Officer by 31st March, 2016.

86. UPDATE FROM IMPROVING LIVES SELECT COMMISSION

Councillor Ahmed reported that the Select Commission had not met since the 3rd February.

One of the areas the Commission would be focussing upon in the 2016/17 Municipal Year would be the scrutiny of CSE Services. Following the meeting in April she would give a detailed update.

87. HEALTHWATCH ROTHERHAM - ISSUES

No issues had been raised.

88. DATE OF FUTURE MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 14th April, 2016, commencing at 9.30 a.m.