HEALTH AND PARTNERSHIPS SCRUTINY COMMITTEE
3 December 2014

PRESENT – Councillor Newall (in the Chair); Councillors Crichlow, Macnab, Regan, EA Richmond and S Richmond. (6)

APOLOGIES – Councillors Donohue, H Scott and J Taylor. (3)

ALSO IN ATTENDANCE – ()

OFFICERS IN ATTENDANCE – Karen Graves, Democratic Officer.

EXTERNAL REPRESENTATIVES – Sharon Pickering, Director of Planning and Performance and Phil Darvill, Planning and Business Development Manager, Tees, Esk and Wear Valleys NHS Foundation Trust and Andrea Goldie, Healthwatch Darlington.

HP35. DECLARATIONS OF INTEREST – There were no declarations of interest reported at the meeting.

HP36. QUALITY ACCOUNTS – BRIEFING - The Director of Planning and Performance gave a PowerPoint presentation which updated Members on the performance against quality priorities and metrics at Quarter 2 2014/15 as at September 2014, outlined early thinking around priorities for 2015/16 and provided an opportunity for Members to discuss and influence plans for delivering the quality priorities for 2014/15.

The presentation shared with Members the Quarter 2 Performance Report which updated Members on progress against the four key quality priorities for 2014/15 identified in the 2013/14 Quality Account as well as performance against the agreed quality metrics, national targets and regulatory requirements and mandatory indicators.

The Director of Planning and Performance explained the four Quality Priorities for 2014/15, as follows:-

- **Priority 1** - To have more staff trained in specialist suicide prevention and intervention.

- **Priority 2** - Implement recommendations of Care Programme Approach (CPA) review, including :

    - Proving communication between staff, patients and other professionals; and

    - Treating people as individuals.

- **Priority 3** – Embed the recovery approach (in conjunction with CPA).

- **Priority 4** – Manage pressure on acute inpatient beds.

Members noted that Priorities 1 and 4 were behind although Priorities 2 and 3 were on track.

In relation to Priority 1 it was highlighted that the Trust was ensuring that staff were confident and trained in specialist suicide prevention and intervention. A recent review highlighted staff confidence issues as an area for improvement. The Patient Safety Group, a sub-group of the Quality Committee, was due to receive the results of the review and agree a developed framework for suicide prevention.

The priority was being taken forward using the Trust Project Management Framework and as such a Project Manager had been identified to support the delivery of the project. Unfortunately the resignation of the Project Manager had caused a delay in achieving the identified milestones.

The Trust was in the process of developing a training and implementation plan which was to be rolled out to staff. Given the significant number of staff that required the training there was a need to identify the priority groups that would receive the training first and this was likely to help the crisis teams given the nature of the work they undertake. By Quarter 4 the Trust hoped to develop a training needs assessment and training plan which would describe who would receive training. This training would be rolled out across the Trust in subsequent quarters.

Members were advised that over a number of years there had been a general decline in suicides although in 2012 there was an increase and the rate of increase in the North East was greater than the national rate. In the last year there had again been a decline.

Members learnt that the Trust was only required to report unexpected deaths as Serious Untoward Incidents (SUI's) where the patient had been on the caseload of the Trust within the six months to their death. If this was not the case then this would become a CCG reported SUI. It was also stated that suicides tended to be young males although more recently older people were being identified.

In relation to Priority 2 Members were advised that the Care Programme Approach (CPA) arrangements had been reviewed and that for the past two years the Trust had been implementing recommendations from that review. Part of the review was to recognise the importance of CPA and to ensure that care was focussed on the patient with the required recording of information not too bureaucratic. The documentation and processes were being re-designed and this had commenced with standard care for patients who required only one professional. Presently the information requirements were the same as more complex needs patients i.e. those on CPA and the Trust was trying to change this process. The Trust was also investigating its risk assessment approach to address key risks.

In relation to suicides who fail, Members were informed that the Trust assumed that people were quite complex and their risk assessment was changed. Patients do tell the

Trust if they are feeling suicidal and the Care Plan was then tailored to their needs. If a suicide attempt was successful an investigation was undertaken to determine if anything had changed or if the Care provided had fallen short of what would have been expected. Care Plans were produced in negotiation with services users to ensure the patients reached their goals.

It was also stated that the number of SUI's occurred and progressed against the actions identified from the SUI reviews were discussed monthly, by the Executive Directors, to monitor overall trends to ensure that any actions identified following an SUI had been implemented.

Details were supplied of developing 'model lines' which would need a full presentation to Members and comprised detailed pathways for service users. It was stated that the standard of service differed across the Trust and one of the aims of the model lines work was to ensure the same standard of care was received by the service user no matter where the Trust was entered. Dr Ruth Briel would be happy to attend a future meeting of Scrutiny to expand further on this piece of work.

Priority 3 related to embedding the recovery approach and Members were advised that key areas which included CPA reviews, model lines and risk assessments were all inter-linked and came together with recovery. A key part of this approach aimed to increase the opportunities for people with mental health issues to gain employment and as such the Trust had increased opportunities for volunteering with 17 new roles being created. Volunteers also had the possibility of becoming peer mentors who showed new service users that there 'was light at the end of the tunnel'. A Recovery College had been established in Durham, with input from service users and the voluntary sectors, and was providing courses including anger management and how to access benefits.

Priority 4 related to managing pressure on acute inpatient beds and Members were advised that some elements of the plan had been delayed but that the Trust was still expecting to have improved by March 2015. Members noted that there was national pressure on mental health inpatient beds and, since the Trust had formed in 2006, there had only been one incidence of a service user having to be sent out of area which was due to a mis-communication rather than a lack of beds at the time. It was stressed that the Trust had therefore been able to accommodate all patients who needed an inpatient bed from the local populations, however, it couldn't always guarantee that a bed would be available in the patients local hospital e.g. Darlington residents may have to be admitted to Middlesbrough or Lanchester Road in Durham. On average bed usage was at 85 per cent which was in line with good practice in order to ensure there was sufficient capacity for emergency admissions.

Members also noted that the appointment of Expert Practitioner had been delayed and action plans for the five teams with the highest levels of admissions and re-admissions had been developed. A case audit of admissions in Richmondshire was also to be undertaken in Quarter 3 in order to understand the reasons behind the high admission rate for that locality.

Members were also advised of the quality metrics, national targets and regulatory requirements and mandatory indicators for 2014/15.

Patient falls were a concern for the Trust and as a result Trust-wide fall groups had been re-established to help address the increase in falls that had taken place across the Trust.

Members noted the Trust's initial thoughts for Quality Priorities for 2015/16 which included:

- Priority 1: Continued focus on embedding Recovery Approach across the organisation;

- Priority 2: Implement the revised risk management process in Children and Young Peoples Services in order to improve risk assessment and associated care planning to ensure they relate appropriately to the developmental stage of each child and their clinical need;

- Priority 3: Implementation of Positive Behavioural Support in Learning Disability services; and

- Priority 4: Implement agreed approach with regard to Nicotine Management (and Smoking).

Members noted that the Trust's Draft Quality Account would be circulated to stakeholders in mid April 2015 to allow for stakeholders to provide comments for inclusion in the Quality Account prior to final publication by 31 May 2015. Arrangements would be made for a special meeting of this Scrutiny Committee to give consideration to the Final Quality Accounts in 2015.

RESOLVED – (a) That the presentation be noted.

(b) That the Director of Planning and Performance and Planning and Business Development Manager be thanked for their attendance and informative presentation.

(c) That the Democratic Officer make arrangements for a special meeting of Health and Partnerships Scrutiny Committee to give consideration the Trust's Final Quality Accounts 2014/15.