Report to:	**HEALTH SCRUTINY COMMITTEE**
Relevant Officer:	Steve Winterson, Director of Strategic Partnerships and Engagement, Lancashire Care NHS Foundation Trust
Date of Meeting	12 October 2016

LANCASHIRE CARE FOUNDATION TRUST: THE HARBOUR PROGRESS REPORT

1.0 Purpose of the report:

1.1 To provide an update on the information requested at the Resilient Communities Scrutiny Committee's previous special meeting to consider The Harbour which is the Lancashire Care NHS Foundation Trust's (LCFT) adults inpatient mental health facility based in Blackpool. The Resilient Communities Scrutiny Committee was previously responsible for health scrutiny which is now the function of the Health Scrutiny Committee.

1.2 Representatives from LCFT and Blackburn with Darwen Clinical Commissioning Group (the lead commissioner for Mental Health Services in Lancashire) attended special meetings of the Resilient Communities Scrutiny Committee on 12 November 2015 and 14 April 2016.

2.0 Recommendation:

2.1 To consider the paper and ask relevant questions to seek assurance regarding concerns raised about The Harbour.

3.0 Reasons for recommendation:

3.1 To provide sufficient information to assure the Health Scrutiny Committee that the provision of Mental Health Services within The Harbour is robust, high quality, compassionate and safe.

3.2a Is the recommendation contrary to a plan or strategy adopted or approved by the Council? No

3.2b Is the recommendation in accordance with the Council's approved budget? N/A

3.3 Other alternative options to be considered:

Not Applicable

4.0 Council Priority:

The relevant Council Priority is 'Communities: Creating stronger communities and increasing resilience'.

5.0 Background Information

A full report was brought to the Resilient Communities Scrutiny Committee on 12 November 2015 and an update report on 14 April 2016.

The Harbour was opened in March 2015, as part of a long term strategic plan to develop a network of specialist inpatient mental health beds supporting the overall provision of Mental Health Services across Lancashire. It is LCFT's largest Inpatient Unit and provides care for patients and service users not just from Blackpool and the Fylde Coast but other parts of Lancashire too.

In total there are 154 beds at the Harbour, which is a little over 50% of the total adult inpatient capacity for LCFT across the county with the other units being based in Lancaster, Ormskirk, Blackburn and Burnley.

On the Health Scrutiny Committee's Work Programme is an action transferred over from the Resilient Communities Scrutiny Committee which was previously responsible for health scrutiny functions.

This is a progress update around The Harbour mental health care facility improvements. It was requested that the Health Scrutiny Committee would consider a report including a clinician update and compliance with National Institute for Clinical Excellence (NICE) Guidance concerning the Byron Ward incident which occurred in July 2014.

6.0 Update Information

6.1 **The Harbour Improvement Plan**

Many improvements have been made at The Harbour focusing on safe, sufficient, value for money quality of care.

6.2 **Staff training/retention**

The development of staff is one of the current priorities at The Harbour. Regular training is being provided by Human Resources, the Quality Academy and staff with specialisms in specific clinical areas. These include key areas such as mandatory training, management of people and induction for new starters. The introduction of the new performance development review supports the identification of training needs.

Retention of staff is of vital importance and they are encouraged to speak to their line manager if they have any concerns at work in order to, where possible, resolve their concerns. Individuals who have expressed their intention to leave The Harbour have had face to face exit interviews with a manager to ascertain the reasons for leaving and where possible to address any factors that could be resolved and individuals remaining in employment at The Harbour or within the Trust.

6.3 **Safeguarding**

The Safeguarding Service works closely with the Clinical Networks to account for their delivery of safeguarding practice and compliance. The Safeguarding Team provides a specialist safeguarding service that supports learning and competency through co-ordination of training, supervision, advice and consultancy to all front line practitioners, their managers and fellow professionals.

A review was undertaken of our Advice and Consultancy (ANCOG) service in response to increased demand and need. There is now a single dedicated telephone line to the service and a dedicated administrative support handling the calls.

The Safeguarding Adults Practitioner and the two Safeguarding Children Practitioners continue to be very visible within the Mental Health wards and teams attending team meetings, delivering bespoke training and attending safeguarding meetings at every opportunity. There are three specialist Mental Health Safeguarding Practitioners who continue to support mental health staff in particular, as well as the wider

LCFT Safeguarding Team.

The Safeguarding Team facilitates the LCFT training programme, supervision agenda and Safeguarding advice and consultancy duty telephone rota.

Bespoke training for the Blackpool Safeguarding Board around safeguarding and mental health continues to be delivered on a quarterly basis. The courses have a good uptake and very positively evaluated, with trainer knowledge being highlighted as a strength. The course remains on the training programme for both Adults and Children's Boards going forward. Future dates have been agreed.

The Harbour staff are offered bespoke training that covers safeguarding adults training and Mental Capacity Act training on the same day. This has enabled staff to be released from work for a full day to attend training ensuring that the off-duty rota for each ward is completed to reflect that staff will not be on the ward on that day.

These sessions are still ongoing at present but early indication is that they are well attended and staff are being supported to ensure they attend.

The LCFT Safeguarding Team quality assures its safeguarding training against learning outcomes and the impact this has on practice through evaluation. This provides a greater understanding of how staff are building competencies and implementing their learning in practice.

A number of internal audits take place. A Domestic Abuse Audit was undertaken by the Adult Mental Health Network, this will be re-audited later in 2016 to demonstrate any changes and developments in practice.

Following a recent multi-agency audit by Blackpool Children's Safeguarding Board which highlighted areas for improvement within adult providers, the Adult Mental Health Network is seeking assurance for the standards of practice and identify any areas which may be required to strengthen.

The purpose of the audit is to seek assurance that the thresholds for safeguarding are implemented. A quality audit is near completion to examine the progress of Safeguarding referrals made by LCFT staff to Children's Social Care (CSC). The audit also scrutinises the quality of subsequent LCFT involvement in safeguarding meetings and submission of safeguarding reports. The final report is awaited.

LCFT's Safeguarding Adults Team has worked with Blackpool Borough Council's in launching and implementing the Blackpool Safeguarding Adults threshold model. This will help avoid inappropriate referrals and support appropriate alerts to the local authority and timely responses when concerns have been identified. This document has been rolled out across LCFT services.

There is a robust Datix (software system) incident reporting process in place with all incidents being reviewed within Networks and Network Quality and Safety Groups. Safeguarding incidents recorded on LCFT's Datix system are also reviewed by LCFT's Safeguarding Team to ensure all appropriate actions have been taken and immediate practice issues are addressed.

An ongoing programme has been set up by the Safeguarding Team to ensure that each ward at The Harbour is visited on a regular basis by a member of the Safeguarding Team. These visits coincide with the ward handover meeting and allow staff to be part of the discussions around each individual patient. The safeguarding practitioners have been able to support staff in identifying safeguarding issues.

Engagement in the work of Blackpool Safeguarding Boards continues to be given a priority. A Specialist Safeguarding Practitioner is the nominated representative on the Training Sub-Group.

A Specialist Safeguarding Children Practitioner continues to be involved in the Blackpool Safeguarding Children's Board Multi-Agency Audit Sub-Group. The audit for quarter one (April - June), 2016-2017 was an 'Audit of joint working between adult drug and alcohol services and children's services'.

The Prevent Agenda, tackling extremism and risks to vulnerable people, continues to be a high priority across the Trust. Training compliance continues to increase slowly.

There is an LCFT model of safeguarding champions within each clinical Team. Regular update meetings are held with champions, with expert speakers being invited to the meetings in order to increase the champions' knowledge around safeguarding. This allows clinical staff to have access to a safeguarding champion at any time to support and sign post where safeguarding issues are identified.

6.4 **Modelling demand/need for optimum number of beds and community services**.

LCFT are working with Blackburn with Darwen Clinical Commissioning Group, the lead commissioner for mental health, to finalise the optimum bed model for Lancashire. It is increasingly clear that, while admission to hospital for treatment is the right option for many patients, for many other patients there are more effective treatments that can be offered if they are available. Such options include short-term and medium-term crisis support and specialist intensive psychological treatment as offered by the new Acute Therapy Service. Importantly, patients accessing these services tell us that they are preferable to inpatient admission. Furthermore, LCFT have opened to specialist Assessment Wards in 2016, in addition to existing bed stock.

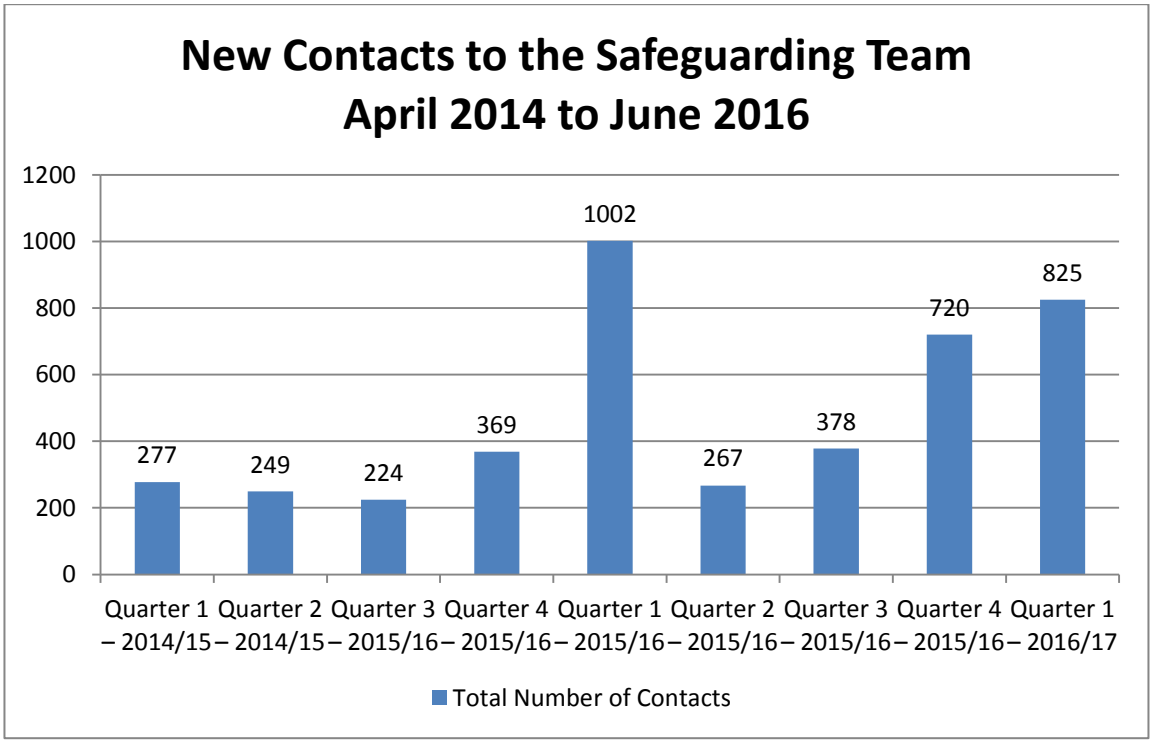
We have found that the initiatives introduced this year (Crisis Support Unit, Acute Therapy Service, Assessment Wards, Step-down Housing) are effective; the key question now is the level of demand for each of these services alongside inpatient admission demand. With these alternative treatment options in place, we are currently able to provide 24.6% of people who would previously been admitted to hospital a more appropriate intensive support option.

As with bed modelling, the review of community services will focus on the required range of services and the necessary capacity in order to keep people well in the community and also to provide more intensive support in the community that means that people do not need to be admitted to hospital. We know that our current services are effective in supporting and treating people, when compared to similar services elsewhere in the country. The focus of service development will be on people who are not open to our services and find themselves needing urgent intensive support.

LCFT and commissioners are reviewing both the bed model and the community services that are required to support the bed model, and are due to make their initial report in October 2016.

6.5 **Safeguarding Reporting**

Comprehensive reporting is undertaken, examples of which are shown overleaf.



The spike in Quarter One 2015-2016 was an error due to revised data collection systems and duplicate recording. There are now consistent recording systems in place across the service.

Contacts to the Safeguarding Team for advice and support have however risen sharply in Quarter Four (2015-2016) and again in Quarter One 2016-2017.This may be attributed to the increased awareness of the Safeguarding Adults' agenda, increased responsibilities and complexity of cases that staff are engaged in.

The table below highlights incidents at The Harbour categorised as safeguarding for Quarter Four 2015-2016 and Quarter One 2016-2017.

Datix incident reporting Category	January to March 2016 Quarter Four 2015-2016			April to June 2016 Quarter One 2016-2017			Trend from Q1 to Q4	Grand Total
	Older Adult In Patient	Adult In Patient	Total for Quarter	Older Adult In Patient	Adult In Patient	Total for Quarter		
Admission of a minor		1	1			0	↓ 1	1
Assault	55	11	66	70	9	73	↑ 15	145
Deprivation of Liberties (DOLS) Application	1	1	2	1		1	↓ 1	3
Pressure ulcer grade 3					1	1	↑ 1	1
Pressure ulcer grade 4		1	1			0	↓ 1	1
Self-harm (actual)					1	1	↑ 1	1
Self-harm (attempted/suspected)		1	1			0	↓ 1	1
Sexual assault		2	2			0	↓ 2	2
Vulnerable adult	4	6	10	4	7	11	↑ 1	21
Grand Total	**60**	**23**	**83**	**75**	**18**	**93**	**↑ 10**	**176**

All the above incidents are reviewed and actions taken accordingly. Out of the 176, 88 cases were alerted to the local authority.

During July 2016 there were 44 incidents reported by staff at The Harbour whereby it was perceived there was a safeguarding issue.

Ten of these cases were alerted to the local authority as required.

- Eight of the cases related to patient on patient assault.
- One threat of violence
- One patient falling/slipping.

Five of the ten incidents were alerted by the Adult Mental Health Network and five from Adult Community Network.

No same patient was involved more than once in the incidents in July 2016.

6.6 **Incident on Byron Ward**

Details of the independent investigation into an incident involving serious self-harm at the Harbour, Blackpool in July 2014 which led to the death of a patient (referred to as patient S) were included in the Trust's previous report to the Resilient Communities Scrutiny Committee.

A series of recommendations were developed for LCFT to consider in response to the concerns identified within this report, around the following themes.

- oversight and coordination of patient care at ward level

  Daily Multi-Disciplinary Team (MDT) discussions are in place with a new structure. "Nerve Centre" is being used to record on which is then copied to Electronic Care Record (ECR) for accuracy and consistency. A Matron visits the ward daily and a weekly 'complex discharge and delayed discharged' meeting is in place to ensure patient care is coordinated and consistent.

- observation monitoring

  A new observation policy in place and all the staff that were involved in S's care received training about completing observations, handing over to each other and accurate documentation.

- clinical decision making processes

  Clinical decision making is via the MDT only unless pre-agreed. Daily MDT discussions are in place to oversee such decisions and a Modern Matron periodically sits in the ward reviews to ensure we are compliant with policies and guidance

- management of people with a diagnosis of Emotionally Unstable Personality Disorder and consistency of practice with NICE Clinical Guideline 78 (2009) and Quality Standard 88 (2015)

  Specific training has been delivered to the nursing team around nursing patients with personality disorder; this is provided on a rolling programme. Furthermore, a Consultant Psychologist assigned to Byron Ward is reviewing the care and treatment of all patients and specific work is being undertaken around assessment and formulation in addition to advising the MDT and assisting staff with delivering

care

- incident reporting and management escalation

  Daily Matron huddles are in place and Datix reports are being received via email on submission of an incident. Daily handovers to the Matron ensure incidents are being reported appropriately. Monday to Friday we have a 24 hour Matron cover on site who visit the ward each shift and in addition to this we have Matron cover during the nights on Saturdays and Sundays.

- adult safeguarding

  Mandatory compliance for adult safeguarding has improved and this is a key target for the ward / unit.

- learning from incidents

  The newly formed Investigation and Learning team has a specific function around thematic analysis from all incidents and will work with the clinical networks across the Trust to share the learning and ensure continuous improvement. We regularly undertake learning events such as Schwarz rounds and "Dare to Share" events. In addition, the Trust Board receives a patient story at the start of every board meeting to support top level scrutiny and assurance.

- Compliance with National Institute for Clinical Excellence (NICE) Guidance

  The Trust has a specific lead role for ensuring then all NICE Guidance is reviewed on publication and that where appropriate the Trust is adhering to that guidance. In addition it formed part of the recent Care Quality Commission (CQC) full inspection. Review of practice through nursing forums is ongoing.

6.7 **CQC review on lessons learnt following deaths**

Following the death on Byron Ward a detailed and extensive action plan was developed: this consists of a network action plan and a corporate action plan. These are monitored through governance meetings.

Similar processes are in place for all Serious Incidents.

Since the incident the network has strengthened the governance in relation to action planning through the appointment of a Governance Lead who has a key role in monitoring the implementation and sustainability of action plans and ensuring the evidence provided to support them is accurate and robust.

Monthly meetings are held with the Lead Commissioner for Mental Health (Blackburn with Darwen CCG) the Associate Director of Safety and Quality Governance and the Head of Investigations and Learning to review progress and monitor implementation of actions plans prior to closure on STEIS (Strategic Executive Information System).

LCFT serious incident guidance being developed

The Trust has developed a new Investigations and Learning Team – independent of all clinical networks - comprised of a number of senior clinicians experienced in Serious Incident investigations. The Investigations and Learning Team is undergoing a detailed induction program and will be fully operational and undertake all Serious Incident investigations in LCFT from October 2016.

The purpose of the Investigations and Learning Team is to improve the quality of Serious Incident investigations and the learning from them; improve the experience of service users, carers, families and

families of victims in relation to the investigation process, being open, the statutory duty of candour and involvement in the investigation process. All receive a copy of the anonymised final report (unless they have requested not to) and meet face to face with the investigation lead to go through the findings.

The Investigations and Learning Team has developed a Standard Operating Procedure that embeds best practice in Serious Incident investigation into day to day work of investigators.

The Nursing and Quality Directorate has employed three Business Partners, to be embedded within network governance, part of whose role is to provide challenge and support to the network with respect to actions plans from Serious Incidents, Complaints, CQC inspections Quality Seal etc.

The Trust has made significant improvements to its Serious Incident process in the light of the Mazars report. The Mazars consultancy firm were commissioned to undertake an independent review into the deaths of people with a mental health or learning disability condition who were registered with Southern Health NHS Foundation Trust between April 2011 and March 2015. A clear audit trail has been established regarding the rationale for the level of investigation commissioned by LCFT for each Serious Incident. A weekly summary report is submitted to the Executive Management Team in which any significant concerns are highlighted.

The Trust has established a Lessons Learned bulletin to be shared across the Trust.

Further improvements to the business continuity of the Serious Incident process are currently being developed as a consequence of centralising Serious Incident investigations with the Investigations and Learning Team.

Assurance that issues identified within the CQC inspection report are being addressed.

The CQC inspected the Trust again in September 2016. The CQC report will provide independent assurance that issues identified within the previous CQC inspection report have been addressed.

6.8 Does the information submitted include any exempt information? No.

6.9 **List of Appendices:**

Appendix 3 (a) – Minutes of Resilient Communities Scrutiny Committee held on 14 April 2016
Appendix 3 (b) – Minutes of Resilient Communities Scrutiny Committee held on 12 November 2015
Appendix 3 (c) – Healthwatch Blackpool's report of service users' experiences undertaken in April 2016 'The Harbour Conversation Project'.

7.0 Legal considerations:

Not applicable.

8.0 Human Resources considerations:

There are no Human Resources implications for Blackpool Council.

9.0 Equalities considerations:

As the beds are managed across the county, there are no equalities issues.

10.0 Financial considerations:

There are no financial implications for Blackpool Council.

11.0 Risk management considerations:

Both the staffing and financial risks are being actively managed through the Trust's risk management and assurance processes.

12.0 Ethical considerations:

Not applicable.

13.0 Internal/ External Consultation undertaken:

This is not a consultation issue, but there is ongoing communication at an executive level with Commissioners, service users and their carers and other stakeholders.

14.0 Background papers:

14 April 2016 http://democracy.blackpool.gov.uk/ieListDocuments.aspx?CId=237&MId=3521

12 Nov 2015 http://democracy.blackpool.gov.uk/ieListDocuments.aspx?CId=237&MId=3882