MINUTES OF HEALTH SCRUTINY COMMITTEE MEETING –
WEDNESDAY, 12 OCTOBER 2016

Present:

Councillor Hobson (in the Chair)

Councillors

Callow	I Coleman	Hutton
Mrs Callow JP	Elmes	

In Attendance:

Councillor Kath Benson
Councillor Amy Cross, Cabinet Member for Health Inequalities and Adult Safeguarding
Councillor Alistair Humphreys
Councillor David O'Hara
Councillor Danny Scott
Councillor Vikki Singleton

Dr Leon Le Roux, Clinical Director, Lancashire Care NHS Foundation Trust
Mr Steve Winterson, Director of Strategic Partnerships and Engagement, Lancashire Care NHS Foundation Trust
Bridgett Welch, Associate Director of Nursing (Safeguarding), Lancashire Care NHS Foundation Trust

Karen Smith, Deputy Director of People (Adult Services)
Les Marshall, Head of Adult Social Care
Jayne Gornall, Senior Service Manager, Mental Health and Learning Disabilities
Chris Kelly, Senior Democratic Services Adviser
Sandip Mahajan, Senior Democratic Services Adviser

1 DECLARATIONS OF INTEREST

There were no declarations of interest on this occasion.

2 PUBLIC SPEAKING

The Committee noted that there were no applications to speak by members of the public on this occasion.

3 LANCASHIRE CARE FOUNDATION TRUST: THE HARBOUR PROGRESS REPORT

Mr Steve Winterson, Director of Strategic Partnerships and Engagement, Lancashire Care NHS Foundation Trust (LCFT) explained that progress reports had been given in November 2015 and April 2016 to the Resilient Communities Scrutiny Committee concerning The Harbour, LCFT's adult in-patient mental health facility in Blackpool.

Improvements had been sought following public concerns and a Care Quality Commission

(CQC) inspection in 2015. The inspection and resulting improvement plan had covered LCFT's services across Lancashire including The Harbour.

More details had been requested following the April 2016 meeting concerning safeguarding of patients and the serious incident that resulted in a suicide on the Byron Ward (psychiatric care) in July 2015. Members noted that the Coroner had recently concluded his public inquest into the incident so comprehensive information was available.

Dr Leon Le Roux, Clinical Director, LCFT referred to the range of improvement work, challenges and plans.

Staffing and Patient Care

Dr Le Roux stated that staffing was arguably the biggest challenge trying to ensure that staff resource, including nurses and doctors, was sufficient, highly skilled and the coverage right at all times. A Staff Strategy had recently been developed.

Dr Le Roux explained that recruitment was an ongoing demand with staff shortages often covered by agency staff and the Trust's own (on-call) 'banked' staff. He acknowledged that using agency staff was not ideal in terms of continuity and familiarity of staff and higher costs but stated that permanent staffing was a national problem and agency staff allowed greater flexibility although the Trust was aiming to eliminate use of agency staff. He added that securing medical staff at consultant level was particularly difficult and there was a high vacancy rate.

Members queried whether staff turnover was high for nursing staff due to their stressful occupations and what was learnt through staff exit interviews. Dr Le Roux explained that turnover of all staff was at times as high as 20%. However, with the use of banked staff, average rates were 50% better than a year ago. He noted that there had been an expected legacy issue when The Harbour had opened in 2015 whereby some staff had been geographically displaced so had chosen to work closer to home. Members expressed disappointment that development plans had been pursued notwithstanding awareness of staffing issues. They queried how many original staff remained and requested a written reply. Mr Winterson explained that LCFT's Chief Executive had addressed early staffing issues at previous meetings. Bridgett Welch, Associate Director of Nursing (Safeguarding) added that the Trust had been nominated as one of the Top 50 NHS employers and highly recommended for patient care.

Dr Le Roux agreed that staff were working in a tough environment where patients needed considerable care and emphasised the importance of retaining staff through effective support and training. He advised that banked staff had access to all training and some training was available to agency staff. Members queried how agency staff qualifications were verified. Ms Welch explained that recruitment agencies were responsible for vetting their agency pool. The Trust was also trying to set up its own agency in addition to its pool of banked staff. Members requested written information in relation to the numbers of

newly qualified staff when the Harbour started and the current numbers. Dr Le Roux gave an assurance that there was a good number of experienced staff.

Dr Le Roux added that sickness levels were an indicator of stress and levels were relatively low at 6.5% and decreasing. Ms Welch added that initiatives were in place such as a People Plan, a new Occupational Health provider and increased nursing supervision support across clinical networks. Dr Le Roux added that clinical psychologist numbers had been increased across wards and that the psychologists talked to patients and supported nursing staff through discussing cases, complex issues and providing briefing updates. Ms Welch added that those were opportunities for staff to share experiences and that the Personal Development Review (PDR) process was another opportunity for staff to pursue personal development. Members requested the results of the staff survey.

The Committee sought assurance that ward numbers were sufficient. Dr Le Roux stated that ideal bed occupancy rates would be 85% allowing capacity for emergency cases. However, rates of 95% were being experienced which equated to the national average and required extra staff. He stated that robust systems had been introduced so that staffing across wards could be monitored at any time including shift handovers. Daily electronic reports of shift patterns and patient requirements were reviewed by ward management including senior nursing staff (matron) and the Director of Nursing which allowed issues to be identified and practical action taken. Senior management also spent time on wards including week-ends. Dr Le Roux advised that there was always a range of operational and strategic staff at all levels either on-site or on-call. He added that there were good communications to ensure resilience for major incidents.

<u>Safeguarding</u>

Ms Welch explained that the Trust had statutory duties to comply with safeguarding legislation (Children's Act 2004 and Care Act 2014 for adults) although they provided no children's services in Blackpool. Members noted that there was a dedicated Safeguarding Team covering children's and adult services as well as mental health and that the Trust provided a wide range of training, ongoing support and advice to all staff. Safeguarding plans were linked to the Trust's quality plans.

Ms Welch stated that a proactive 'learning through practise' approach was undertaken with staff as well as bespoke training based on real experience.

It was reported that at the local level, the Safeguarding Team worked closely with the Blackpool Safeguarding Boards for children and adults as well as the other two safeguarding boards in Lancashire at a strategic board level and an operational level, as well as specific training and quality sub-groups and case reviews. She reported that the Team were involved with multi-agency audits of specific themes and cases as well as their own internal audits. In response to a question, she confirmed that the Safeguarding Boards independently audited the LCFT. Members noted that the Trust worked closely with the Council's services for children and adults and the Designated Nurse for

Safeguarding from the Clinical Commissioning Group (Blackburn with Darwen as the lead commissioner).

Ms Welch referred to the high number of safeguarding alerts raised concerning The Harbour and stated that a significant number had been due to being cautious and applying risk thresholds inappropriately. Ms Welch stated that too many unnecessary referrals put pressure on officers at the various safeguarding bodies and it was hoped that improved training for all staff would create a better understanding of thresholds and when referrals were appropriate. She added that it was good that staff had the confidence to make referrals. The Committee was advised that the Trust bench-marked their safeguarding performance against national standards for comparable NHS trusts.

It was reported that the Trust had been involved in helping re-design thresholds guidance for adults and Ms Welch took members through the safeguarding reporting and focused on the alerts that had been considered as genuine safeguarding concerns. A software system 'Datix' was used so that all incidents were investigated to ensure that there were no safeguarding concerns. Part of the awareness process involved the Safeguarding Team visiting wards and discussing best practice. Ms Welch stated that it was important to focus on protecting vulnerable people and supporting their needs but also recognising that incidents may not necessarily pose a risk. Members referred to recent press articles concerning patients wandering in the community seemingly lost. Dr Le Roux explained that patients were not in secure institutions (unless sectioned) and the focus was on caring for them to support recovery. Risk assessments were done and mitigation measures put into place to manage risk which could not be totally eliminated. He advised that that particular patient had been assessed and deemed to be safe to leave the grounds.

Ms Welch added that the Trust forecasted safeguarding demand pressures. She referred to the high numbers of assaults, which could include threats or offensive comments and explained that the assaults did not involve staff on patients. Ms Welch advised that there was zero tolerance to any type of assault so they were all investigated and members noted that multiple assaults could be recorded when one patient was particularly unwell and abused several people. In response to a question, Ms Welch confirmed that there were more assaults on older patients but that those reflected The Harbour's patient population. Members requested a written breakdown of the different types of assaults and numbers. In response to a suggestion for trained security staff helping with reducing the number of assaults, Dr Le Roux stated that The Harbour was an environment that endeavoured to provide care and recovery support for patients rather than a secure institution.

Members noted that the assaults and other issues had created a negative public image of The Harbour amongst some local residents who had raised concerns and conversely other residents had recognised the work of The Harbour. It was suggested that one proactive approach could be to create a more attractive physical environment that supported patients and projected a better image.

Dr Le Roux referred to the challenging patient environment where there were difficult

long-term conditions. He added that it was a constant learning curve for all staff and they recognised the need to be open to suggestions.

Serious Incidents

The Chairman referred to Healthwatch Blackpool's report undertaken in April 2016 concerning service users' experiences of The Harbour. Users had been concerned by the constant change of staff and not being available when patients needed them. Dr Le Roux explained that there were no bell pull cords (for safety) or other alarm for patients as it was felt they had the physical means to alert staff. There had been bells when The Harbour first opened but technical issues had arisen. He stated that staff now had their own alarms, new staff followed a structured programme including practical introductions to wards and that patients were risk assessed and under constant observation if necessary. Ms Welch added that Multi-Disciplinary Teams (MDTs) operated on wards and there was careful planning in place to manage any serious incidents.

Dr Le Roux referred to the serious incident that had led to a suicide on the Byron Ward in July 2014 and following which an external agency had been commissioned to undertake an independent investigation. He advised that staff had been new and had had limited experience. Members noted that one of the factors highlighted was the over-reliance on the observation policy which had not been strictly followed. It had been recognised that the policy was not clear with different staff interpretations and threshold risk levels for undertaking observation being changed. Dr Le Roux advised that the observation issues had been addressed and supported by training, however, all eventualities could not be guaranteed as staff were trying to manage unpredictable human behaviour. He advised that an enhanced risk assessment tool was used and summarised the main themes identified by the independent reviewer, namely low levels of staff experience, problems with the observation policy, need for robust clinical decision-making in line with national guidance and good management of patients with personality disorders. All the independent recommendations had been accepted and effective actions implemented.

The Chairman referred to the Coroner's findings and that clinical decisions had been made inappropriately. Dr Le Roux acknowledged that there had been failings but policies, procedures and systems had improved with increased training and effective staffing and that there was increased visibility of ward matrons. In response to questions, he added that processes were audited and incidents investigated and assured Members that compliance levels were high and operating procedures kept up-to-date.

Members expressed concern that at the time of the incident important evidence had gone missing. Dr Le Roux explained that often deaths occurred sometime after incidents as was the case for the relevant incident. He stated that 'scene of crime' guidance had been produced for staff concerning incident management including actions such as cordoning off areas at the right time and making use of the CCTV system. Members requested written evidence that procedures had been strengthened for ensuring 'scene of crime' material did not go missing.

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Modelling Demand (Beds)

Dr Le Roux explained that service capacity modelling work had taken place working with the Network Director as providing a diverse service structure with the right capacity was the biggest challenge across Lancashire. Members noted that community provision was provided through a range of teams for patients able to manage their lives in the community with appropriate support and that in-patient beds were for the most acute long-term cases. Dr Le Roux stated that there was no middle option for people who might suffer from mild mental health problems but suddenly experienced short-term acute problems due to a single incident.

Dr Le Roux went on to give an example of a major incident which had occurred when over 90 new patients had suddenly arrived. All options had needed to be considered including working with acute trusts especially as there were no spare private beds.

The Committee noted that some progress had been made to improve bed capacity and plans were being accelerated working with service commissioners. New assessment units had been opened, acute units used and crisis housing support provided.

Dr Le Roux reported that 'out-of-area' bed placements (placing patients in units outside their local area) were a particular issue locally and nationally. Locally that required twice as much work without a parallel increase in staff numbers. He advised Members that the Trust currently had more than double the national average and was the second highest nationally. However, the 'out-of-area' level had recently reduced slightly. Dr Le Roux advised that work was being done with the NHS Benchmarking body to look at best practice at other trusts although change took time and that one London trust had needed eight years to make necessary changes. The Committee noted the government target of zero out of area placements by 2020 and that fundamental strategic changes were required in the health economy to achieve the target.

Members referred to original proposals when The Harbour was built that there would be other new sites. Mr Winterson explained that austerity measures had delayed the proposed new builds. However, there were still plans for two new sites and a written response confirming plans would be provided.

Mr Winterson added that modelling reviews had taken place in 2005-2006 and 2011-2012 and that both had proposed reducing the number of beds significantly and increasing community service provision. Members noted however that beds had significantly reduced since 2005 but the 2011 target of reducing beds to 260 across the LCFT network had not been achieved to the desired range and there were still over 300 of which 154 were at Harbour. Dr Le Roux added that LCFT actually had below average numbers of beds against comparable neighbours which prevented the number of 'out-of-area' placements being easily reduced. He stated LCFT's vision was to reduce ward beds and increase the community focus and that steady progress was being made. He added that the voluntary and community sector was an important asset to work with particularly with respect to social care as part of integrated healthcare. In response to a question, it was confirmed that the Making Spaces charity was an active partner of the Council.

Financial and Long-Term Sustainability

The Chairman referred to recent local press concerns over value for money. Dr Le Roux referred to the financial challenges faced by the Trust and NHS generally. LCFT worked closely with commissioners of their services but also put forward robust, value for money cases for enhanced services. The contract was due for review and all the CCGs would be giving their views as to value provided and what should be provided.

Care Quality Commission Inspections

Mr Winterson referred to the 2015 CQC inspection and explained that there had been around 400 improvements required most of which had been implemented. Longer-term ones concerning the estate were still being pursued. Members enquired as to the provisional outcomes of the recent CQC inspection and Dr Le Roux outlined that the LCFT had been given a positive impression from the CQC who usually highlighted any serious concerns but there had been none indicated. However, LCFT was still pursuing ongoing improvement. The report was expected in November 2016 followed by a Quality Summit in December 2016.

Members noted the progress that LCFT had made at The Harbour in terms of safe and quality patient care and requested the latest CQC findings to provide on-site assurance and inform them as to any further progress reports.

The Committee agreed:

1. That LCFT would provide the following information to be circulated to Members -

    i) Percentage of newly qualified staff when The Harbour started in 2015 and the current percentage.
    ii) Number of original staff retained from when The Harbour started in 2015.
    iii) Results of the latest staff survey.
    iv) Different types of assaults and numbers for each type.
    v) Evidence that procedures have been strengthened for ensuring 'scene of crime' material does not go missing.
    vi) Confirmation of what new in-patient mental health sites were proposed and details of service capacity.

2. To review the CQC report, following their inspection in September 2016 of the LCFT, and use any relevant evidence including the CQC findings, to decide whether specific assurances of safe and quality patient care were still required through further meetings.

4 DATE AND TIME OF NEXT MEETING

The Committee noted the date and time of the next meeting as Tuesday 29 November 2016 in Committee Room A, Blackpool Town Hall.

Chairman

(The meeting ended 8.30 pm)

Any queries regarding these minutes, please contact:
Sandip Mahajan Senior Democratic Governance Adviser
Tel: (01253) 477211
E-mail: sandip.mahajan@blackpool.gov.uk