ANNEX 1

Leeds CITY COUNCIL

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Report of Shona McFarlane, Chief Officer Access & Care Delivery

Report to Scrutiny Board (Adult Social Service, Public Health, NHS)

Date: 27 January 2016

Subject: Waterloo Manor, Medium Secure Hospital

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	√ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	√ No
Is the decision eligible for Call-In?	☐ Yes	√ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	√ No

1. Summary of main issues

The CQC inspection report centred around matters relating to the dispensing and recording of medication interventions, methods of patient management, use of restraint, general patient recording and the formulation and adherence to care planning. As a culmination of all of these components there were significant safeguarding concerns. As previously reported a whole scale safeguarding investigation was conducted and this entire process was concluded in the form of a Thematic Meeting on 30th June 2015 attended by all key partners including NHSE and CQC. As a result there were a number of actions required, manly of Waterloo Manor. There were a number of themes identified through the collective safeguarding investigation including a lack of effective safeguarding training, inconsistent or incorrect implementation of safeguarding processes, understanding of thresholds and a programme of audit with regards to the implementation and recording of restraint and the use of de-escalation techniques to prevent challenging behaviour.

There was some significant multi-agency learning significantly in relation to the ongoing responsibilities of Home Local Authorities in cases where the patient receives full funding

from NHSE. There was also some learning around Waterloo Manor allowing access to investigating social workers in an appropriate setting, rather than interviews or meetings being held in administrative space away from the living areas. It was also agreed that NHSE and CQC would review their working relationship to become clearer in terms of roles and responsibilities and to coordinate those approaches. It was agreed as a governance mechanism that the points evident within the Thematic Review Meeting were to be fed into the Learning and Improvement work of the Safeguarding Adult Board.

2. Recommendations

That the Scrutiny Board considers the report and detail presented at the meeting and determines any further scrutiny activity and/or actions as appropriate. Adult Social Care will retain a key role in support, advice and monitoring and will continue to work with NHSE and CQC.

That Scrutiny accept the reassurances given by Adult Social Care in terms of the significance and importance of attention given to this particular provider.

1. Purpose of report

1.1 The purpose of this report is to provide members of the Scrutiny Board (Adult Social Services, Pubic Health,NHS) with a further update following the Care Quality Commission (CQC) inspection undertaken in February 2015 and the subsequent publication of this report in August 2015. A report outlining the issues and concerns and giving an update on progress made since the initial inspection was presented to Scrutiny Board in September 2015 and this report provides a further narrative in relation to the monitoring and co-work with Waterloo Manor. This report has been completed in conjunction with Adult Social Care and NHS England and provides information from the perspective of both organisations in relation to their respective responsibilities. These are in relation to the Local Authority's statutory duties in respect of Adult Safeguarding as set out in the Care Act and NHS England's perspective as the Commissioners of the service.

1.2 Waterloo Manor is a private hospital providing medium secure Mental Health provision for females. All patients at Waterloo Manor are detained under sections of the Mental Health Act 1983 (2007). The provision at Waterloo Manor continues to be commissioned by NHS England and accepts patients in need of specialised treatment from across England. In terms of provision there are 33 secure beds, 18 locked rehabilitation beds and 5 beds within an open rehabilitation ward.

2. Summary of main issues

2.1 The CQC inspection report centred around matters relating to the dispensing and recording of medication interventions, methods of patient management, use of restraint, general patient recording and the formulation and adherence to care planning. As a culmination of all of these components there were significant safeguarding concerns. As previously reported a whole scale safeguarding investigation was conducted and this entire process was concluded in the form of a Thematic Meeting on 30th June 2015 attended by all key partners including NHSE and CQC. As a result there were a number of actions required, manly of Waterloo Manor. There were a number of themes identified through the collective safeguarding investigation including a lack of effective safeguarding training, inconsistent or incorrect implementation of safeguarding processes, understanding of thresholds and a programme of audit with regards to the implementation and recording of restraint and the use of de-escalation techniques to prevent challenging behaviour.

2.2 There was some significant multi-agency learning significantly in relation to the ongoing responsibilities of Home Local Authorities in cases where the patient receives full funding from NHSE. There was also some learning around Waterloo Manor allowing access to investigating social workers in an appropriate setting, rather than interviews or meetings being held in administrative space away from the living areas. It was also agreed that NHSE and CQC would review their working relationship to become clearer in terms of roles and responsibilities and to coordinate those approaches. It was agreed as a governance mechanism that the points evident within the Thematic Review Meeting were to be fed into the Learning and Improvement work of the Safeguarding Adult Board.

3. Progress to date

3.1 The NHSE Senior Commissioner attends regular meetings with senior management from Waterloo Manor. He has had sight of all new documentation to enable him to have a clear commissioner view and quality assurance oversight. A new pilot project for recording and the reformulation of support plans has been introduced, in that Waterloo Manor has implemented a system that requires support plans to be updated on a fortnightly basis, replacing the previous inadequate process which was a 6 monthly review. The new documentation supporting this combines the multi-disciplinary ward round notes and overall summary and support plans. The benefits of this approach are that support planning is dynamic, timely and tailored to current need i.e. the presenting needs therefore timely and flexible changes are made.

3.2 The commissioner is currently overseeing the implementation of a 10-point action plan, which can be seen at Appendix 1. This focuses mainly on the concerns raised by the CQC. Satisfactory progress is being maintained on this plan. Changes to ward based documentation are being checked at ward level. A new clinical lead for the service commences mid-December who will provide an increased level of staff leadership and supervision. Other senior staff at Board level have also recently been appointed, notably the new role of Director of Nursing and Quality who is responsible for enhancing the quality of care delivery, and a Director of Compliance who has recently implemented a new integrated governance system across the company. Both of these roles bring a significant amount of expertise and scrutiny at Board level, which has started to impact positively at Waterloo Manor in terms of governance and culture. The Nursing Directorate of NHS England is presently organising a further Quality Surveillance Group meeting which will draw together the key stakeholders involved in order to review progress.

3.3 Waterloo Manor have access to the training and development offer from Leeds Safeguarding Adults Partnership and therefore are able to access the comprehensive suite of training on offer. The directorate has provided some training in house specific to Waterloo Manor but this was specifically provided as a result of the concerns earlier in the year as the service had been identified as a special case and prioritised by the Safeguarding service. This approach of providing bespoke training to every provider would not be sustainable therefore Waterloo Manor are now required to access the available training themselves and to attend the dates provided. This is being closely monitored. It is disappointing to note that to date this has not happened and at a meeting with managers from Waterloo Manor recently it was reinforced that this is the expectation. The take up of the training will be closely scrutinised as this is a positive indicator of an organisation taking individual responsibility.

3.4 Senior personnel from Waterloo Manor have reported that they are in the process of introducing internal safeguarding training. This is currently providing by use of an online tool and this needs to be further developed in a more sophisticated way. The provider is currently liaising with NHSE to implement a more comprehensive safeguarding training plan. Adult Social Care have also offered to give support and advice in terms of this via a dedicated link to a ASC manager with specific expertise and experience in the field of safeguarding.

3.5 The provider has acknowledged that they need to provide specific training in relation to working with people with personality disorders. They acknowledge that this is an area where they should demonstrate expertise and that their staff must be sufficiently confident and competent in approaches and risk management and assessment. Adult Social Care have been informed that this training is being commissioned and will be available early in 2016.

3.6 Waterloo Manor are rolling out additional risk management training and this includes the involvement of patients which is recognised good practice and supports the promotion of responsibility where adults have a diagnosis of a personality disorder. In addition to this, training is also mandated for all staff with regards to the Mental Health Act and the Mental Capacity Act. Seeing this training programme delivered comprehensively cross staff teams would provide confidence that the front line staff are fully aware of the legislative frameworks in which they are expected to work. There are clear appeal processes and procedures which are long established within the arena of Mental Health Act detentions and these processes also serve to ascertain quality in relation to the execution of service delivery and to ensure that patient's rights and dignity is being upheld.

3.7 Waterloo Manor have implemented new planning documentation with a focus upon independence and personalised approaches. This demonstrates partnership and inclusive working with patients. The documentation is known as "My Shared Pathway" and this has been shared with commissioners.

3.8 In order to respond to the concerns about safe practices in relation to medication, Waterloo Manor now have implemented an external monitoring and fortnightly stock check via a local pharmacist. This enables robust audit to take place and subsequently the reviews of process are demonstrating that safe practices are in place with regards to medication issues. This will continue to be monitored via NHSE and CQC.

3.9 In relation to the safeguarding investigation and the CQC inspection there were evident concerns about a particular culture existing in that patients were not respected and were not treated with the dignity to which they are entitled. This has been accepted by the senior managers within the company and as such the key appointments at Director level have been changed and new personnel have been appointed in order to facilitate a whole scale change in culture. This does take time and this is acknowledged. The enhanced significance given to training is part of this as is the collaboration with patients. All patients now have access to independent advocacy and this is routinely taken up. There are however still some concerns in relation to the implementation of safeguarding. A morning meeting is held daily focusing upon safeguarding matters and relevant paperwork completed. It is disappointing to note that it is not yet clear via recording which professional takes responsibility for following up safeguarding concerns. Waterloo Manor are currently developing a document as a way of tracking safeguarding and they have been advised to clarify exactly who is responsible for allocated actions.

3.10 Further collaboration with patients is evident as a new system has been introduced where patients are present when their daily notes are being recorded. Patients are encouraged to contribute to their daily notes and communication seems to have improved between staff and patients.

3.11 In relation to previous concerns regarding the over-reliance upon agency staff Waterloo Manor are currently reporting that they have 3.5 current vacant nursing posts out of a compliment of 24 nurses for the hospital. Recruitment is underway for these vacancies. With regards to healthcare assistant posts these are all fully recruited into. Where agency staff are needed this is done via one organisation "Achieve" - this provides a consistency of sorts and this organisation only provide staff where they have received the Waterloo Manor mandatory training to implement and approach where the staff are trained and competent within this particular area of provision.

3.12 From an Adult Care perspective the directorate will continue to provide a link Team Manager to Waterloo Manor for the purposes of monitoring, support and safeguarding oversight. The established process for monitoring entails the receipt of safeguarding referrals which will be logged onto the CIS database and identified against that manager for ease of reference. Waterloo Manor are aware of this and there have been two separate meetings to clearly articulate the process of safeguarding with an explicit focus upon the outcomes that the vulnerable individual wishes to achieve. Adult Social Care are meeting with NHS England at Waterloo Manor in order to establish an ongoing clear partnership approach. The tracking of safeguarding activity will be monitored weekly and any concerns will be immediately flagged up with the provider with Head of Service oversight. There has been a decrease in safeguarding referrals over the past four months. There were two referrals in August - one was an incident between a patient and a staff member and the police have been involved and no prosecution has occured. The investigation evidenced that there was no assault on the patient from the staff member as had been alleged. The second safeguarding incident in August was in relation to a patient bullying another patient. There were no referrals in September and one received in October. This particular referral is currently being investigated by the police and a member of staff has been suspended. There have been no referrals received in November and rigorous monitoring is in place.

4. Recommendation

4.1 That the Scrutiny Board considers the report and detail presented at the meeting and determines any further scrutiny activity and/or actions as appropriate. Adult Social Care will retain a key role in support, advice and monitoring and will continue to work with NHSE and CQC.

4.2 That Scrutiny accept the reassurances given by Adult Social Care in terms of the significance and importance of attention given to this particular provider.

Background Documents:

None

The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.