Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171
www.cqc.org.uk

For the attention of the Chief Executive
Birmingham and Solihull Mental Health Foundation NHS Trust
Trust Headquarters B1
50 Summerhill Road
Birmingham
West Midlands
B1 3RB

16 December 2020

Care Quality Commission
Health and Social Care Act 2008
Notice of decision to impose conditions on your registration as a service provider in respect of a regulated activities

Our reference: RGP1-10053519614
Account number: RXT

Dear Birmingham and Solihull, Mental Health Foundation NHS Trust

We are serving this notice under Section 31 of the Health and Social Care Act 2008.

Urgent notice of decision to vary the conditions of your registration as a service provider in respect of the locations you can carry on a regulated activity from.

Regulated Activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury

We are formally notifying you of our decision under Section 31 of the Health and Social Care Act 2008, to impose conditions on your registration as a service provider in respect of the above regulated activities. We have taken this urgent action as we believe a person will or may be exposed to the risk of harm if we do not do so.

We have imposed the following conditions for the regulated activities stated above:

1. By 4 January 2021, the registered provider must inform the Commission of the order of priority in terms of addressing the ligature risks and timescales for addressing the ligature risks across each ward.

2. The registered provider must take steps to address the ligature risks across all wards by 18 June 2021

3. Commencing from 5 February 2021 the registered provider must report to the Commission on a monthly basis setting out progress being made in respect of and including mitigating measures being put in place until all ligature risks are addressed.

4. By 29 January 2020 the Registered provider must implement an effective system to improve risk assessments and care planning. The Registered Provider must report to the Commission on the steps it has taken in connection with this by 5 February 2021.

5. Commencing from 1 March 2021, the Registered Provider must report to the Commission on a monthly basis the results of any monitoring data and audits undertaken that provide assurance that the system implemented is effective.

These are imposed at or from the following location:

Mary Seacole House
Lodge Road
Winson Green
Birmingham
West Midlands
B18 5SD

- Meadowcroft PICU
- Ward 1
- Ward 2

Northcroft Site
355 Slade Road
Erdington
Birmingham
West Midlands
B23 6AL

- Eden Acute
- George Ward
- Reservoir Court

The Barberry
25 Vincent Drive
Edgbaston
Birmingham
West Midlands
B15 2FG

- Caffra PICU
- Melissa Suite
- Japonica Suite
- Magnolia Suite
- Tazetta Suite

Little Bromwich Centre
192 Hob Moor Road
Small Heath
Birmingham

West Midlands
B10 9JH

- Newbridge House

The Zinnia Centre
100 Showell Green Lane
Sparkhill
Birmingham
West Midlands
B11 4HL

- Saffron Ward
- Lavender Ward

Background/Evidence

We carried out an inspection at Birmingham and Solihull Mental Health Foundation NHS Trust from 16 November 2020 to 25 November 2020. The inspection raised a number of concerns, which are set out below:
We have made this decision for the following reasons:

- Since 2013 there have been eight suicides in the trust where ligatures have been used by patients to take their lives. Bathroom doors and bedroom doors have been used as anchor points in some of the eight episodes. The deaths occurred in the following areas: Mary Seacole Ward 1 and 2; Eden male unit: Eden PICU: Reservoir Court: Lavender ward and Severn ward. The most recent suicide took place in September 2020 on Mary Seacole 2.
- The commission's inspection of the trust in 2014 raised concerns about the safety of patients on Mary Seacole House. The trust was asked to address the ligature risks identified at Mary Seacole. The trust in its action plans confirmed it had completed an annual environmental risk assessment for all wards on Mary Seacole House and installed domed mirrors to improve blind spots in different areas. Specifically, to Mary Seacole Wards 1 and 2 installation of anti-ligature windows and door combinations.
- At the comprehensive inspection in 2017 the commission identified that potential ligatures had not been fully addressed on Newbridge House, George ward, Eden PICU and Eden acute ward. The trust addressed the concerns by taking several actions including installing anti-ligature windows, Safehinge anti-ligature hinged doors and locks to bedrooms as well as a range of other actions inside and outside of the wards.
- In May 2020 the trust informed the commission of the death of a patient who had committed suicide using the en-suite bathroom door as an anchor point. A review of the death raised concerns about risk assessments, the risks associated with the en-suite bathroom doors, the quality of care plans and the lack of professional curiosity in patients. The trust confirmed they were to change the en-suite doors on Mary Seacole Ward 2 and ensure that alarms would be fitted to tops of all door which would alert staff if a ligature was attached.
- In September 2020, CQC were informed of another patient on Mary Seacole Ward 2 creating a ligature and anchoring it to the hinge on the en-suite bathroom door. The patient was revived and taken to hospital but sadly died later. The doors on Mary Seacole had not been changed or fitted with the alarm system to prevent patients anchoring a ligature
- During our most recent inspection 23, 24, 25 November 2020, we carried out a visual check of six of the acute service wards, Eden PICU, Mary Seacole Wards 1 and 2, Saffron and Lavender wards at the Zinnia Centre and Japonica ward at Oleaster. We found that only Eden PICU had undertaken some remedial work to mitigate the risk of ligation using the en-suite

bathroom doors as an anchor point. This work had been undertaken in the two rooms that had en-suite bathrooms. One door had been fitted with an alarm as part of a trial and one with a specialist saloon type door that was held on with magnets. None of the other rooms had en-suite bathrooms and as such the risk had been reduced in this unit. We observed that work was underway on Mary Seacole Ward 2 to replace the doors throughout the ward and we were informed that work was completed several days after the inspection date. In relation to the other wards, the trust did not have any firm plans or timeframes as to when this risk would be addressed at the other sites

- We spoke with six staff members. We were told by five staff during our inspection that they did not know when the risks presented by the en-suite bathroom doors would be addressed on the following wards. Japonica, Mary Seacole Ward 1, Saffron and Lavender wards.
- The inspection team reviewed 11 care plans, risk assessments, multi-disciplinary records and continuation notes. We found care plans did not clearly identify how staff should manage the risks identified in the level 1 risk assessments. There is a risk that staff will not know how to manage or reduce risks that have been identified in the risk assessments leading to patients self-harming, thereby exposing them to harm.
- Of the 11 care plans we checked across all wards, seven had risks identified in the risk assessments that were not addressed in care plans. These included risks to self, risks to others and risk of self-neglect We found 11 examples where part or all the care plans used generic language and did not consider the individual's voice.
- Following our inspection, there were continued serious concerns about how you would mitigate the ligature risk pending all doors being replaced. You did not have any clear measures in place to mitigate the risk of service users committing suicide. We also had concerns that care plans did not clearly identify how staff should manage the risks identified in the level 1 assessments., As a result, we sent you a letter of intent on Friday 10 December 2020. We also sought assurances from you as to immediate actions you would take to address our concerns pending your response. This was provided.
- You submitted a response to our letter of intent on Monday 14 December 2020, setting out a timetable to implement changes to the areas of risk identified. We are not assured that your timetable deals with immediate risks to patients and the timescales for implementation is set over a long period of time with works not due to be completed until 2023, thereby leaving in place risks meaning patients will or may be exposed to the risk of harm.
- This decision takes effect immediately when this notice is given and you must carry on the regulated activities in a way which complies with your conditions of registration, including this imposition.

If you do not agree with our decision, you have the right to make an appeal to the First-tier Tribunal (Health, Education and Social Care Chamber) under Section 32of the Health and Social Care Act 2008. You should make your appeal using the correct appeal application form which can be downloaded from the Tribunals Service website (https://www.gov.uk/courts-tribunals/first-tier-tribunal-care-standards) or copies can be sent to you by contacting the Tribunals Service using the details below.

You must make your appeal in writing within 28 days of the date this notice was served on you and send it to:

HM Courts & Tribunals Service
Care Standards
1st Floor
Darlington Magistrates' Court

Parkgate
Darlington
DL1 1RU
Tel: 01325 289350
Fax: 01264 785013
cst@hmcts.gsi.gov.uk

If you do not want to make an appeal against our decision, please let us know in writing before the end of the 28 day period. If you do not make an appeal, our decision will become final as soon as we receive your letter or at the end of the 28 day period, whichever is sooner. If you do make an appeal, the final outcome will depend on the decisions made by the Tribunal.

You should contact the Tribunal Service if you have any questions about the tribunal process or making an appeal.

If you have any questions about this notice, you can contact our National Customer Service Centre using the details below:

Telephone: 03000 616161

Email: Enquiries@cqc.org.uk

Write to: Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote our **reference number** at the top of this notice, as it may cause delay if you are not able to give it to us.

Yours sincerely

Dr Kevin Cleary
Deputy Chief Inspector, lead for mental health