

CARE QUALITY COMMISSION – ACTION PLAN IN RESPONSE TO SERIOUS CONCERNS RAISED BY CARE QUALITY COMMISSION FOLLOWING FOCUSED INSPECTION IN NOVEMBER 2020

Concern Raised: 'Patients at the trust are not protected from the risk of self-harm because en-suite doors identified as ligature points have not been removed or sufficiently mitigated to ensure the safety of your patients. This places patients at significant risk of serious self-harm to their lives and safety'.

This action plan firstly details the immediate actions we are taking to reduce ligature risks and the risk of self harm associated with en-suite bathroom doors across our acute and PICU inpatient estate. We include our timetable for implementing the door change on en-suites in all acute admission wards and PICU and when the programme of replacement of doors will be completed. Later in the document we include actions that we have completed to date with the aim of progressing mitigation of this risk.

Key to Status Column:-

Complete	Green
On Track to achieve target date	Yellow
Slippage	Red

Immediate and Future Actions							
Unique Ref Number	Concern Raised	Actions Identified	Planned Completion Date	Actual Completion Date	Lead Individual	Actions Taken	Status
LAP10(2)	Patients at the trust are not protected from the risk of self-harm because en-suite doors identified as ligature points have not been removed or sufficiently mitigated to ensure the safety of your patients. This places patients at significant risk of serious self-harm to their lives and safety.	Risk mitigation items were identified 11 December (see action under LAP10 (1)). Finalise costings and works for the further programme of ligature risk reduction adaptations whilst awaiting the roll out of door alarm systems across acute inpatient facilities and PICUs to be completed	18 December 2020	18 December 2020	XXXXRedactedXXXX	Work programme fully costed for interim works and considered not viable due to increased fire and flooding risk. Plan agreed for enhanced relational and procedural controls to be implemented to manage ligature risks.	Complete
LAP10(3)	Patients at the trust are not protected from the risk of self-harm because en-suite doors identified as ligature points	Agree timeline for implementation of works programme for ligature risk reduction adaptations whilst awaiting the roll out of door alarm systems across acute inpatient facilities and PICUs (See action under LAP10(2)).	30 December 2020	18 December 2020	XXXXRedactedXXXX	See comment in LAP10(2) above	Complete

	have not been removed or sufficiently mitigated to ensure the safety of your patients. This places patients at significant risk of serious self-harm to their lives and safety.						
LAP09(4)	Patients at the trust are not protected from the risk of self-harm because en-suite doors identified as ligature points have not been removed or sufficiently mitigated to ensure the safety of your patients. This places patients at significant risk of serious self-harm to their lives and safety.	Commence implementation of final extended works programme for the roll out of ligature door alarm solutions for all acute inpatient wards and PICU plus Reservoir court	January 2021	January 2021	XXXXRedactedXXXX	Surveys are complete on all acute inpatient wards and PICUs, with the exception of Larimar Ward due to COVID outbreak. Survey is complete on Reservoir Court.	Complete
LAP07(2)	Recommendation from inpatient suicide cluster review	Additional therapeutic activities to be in situ on Mary Seacole 2, Lavender Newbridge & Larimar Acute inpatient Wards	31 January 2021	January 2021	XXXXRedactedXXXX	Menu of activities developed. Activities schedule in place on MS2, Lavender and	Complete

						Newbridge and Larimar.	
LAP08(2)	Recommendation from learning from counterpart mental health NHS trusts	Decision to be taken on use of remote patient safety technologies within Acute In patient wards and PICU's	31 January 2021	20 January 2021	Integrated Quality Committee	Paper received at CGC 5.1.21. Recommendation went to IQC 20 Jan 21 to not invest at this stage and this was accepted.	Complete

An accompanying document details the interim actions that the trust is taking to mitigate the risks associated with en-suite doors and how they will keep patients safe until the replacement of doors is completed.

Unique Ref Number	Concern Raised	Actions Identified	Planned Completion Date	Actual Completion Date	Lead Individual	Status
Historic actions 2014-November 2019						
2014/01	CQC Inspection 2014 - Breach of Regulation 15 (1) (a) MUST DO The Trust must ensure that people on Mary Seacole House are protected against the risks associated with unsafe or unsuitable premises; by means of suitable design and layout.	Please see attached document which details all ligature reduction works and environmental improvement works completed in response to this breach of regulation	Please see attached document	Please see attached document	XXXXRedactedXXXX	Completed
	Breach of Regulation 15 (1) (a) Must Do The Trust must ensure that the ligature risks identified at Mary Seacole House are risk assessed and addressed.	Please see attached document which details all ligature reduction works and environmental improvement works completed in response to this breach of regulation	Please see attached document	Please see attached document	XXXXRedactedXXXX	Completed

Unique Ref Number	Concern Raised	Actions Identified	Planned Completion Date	Actual Completion Date	Lead Individual	Status
2017/01	<p>CQC Inspection 2017 - Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Must Do Newbridge House, Eden PICU, Eden Acute and George Ward had potential ligature points that had not been fully managed, mitigated, or addressed SHOULD DO</p> <p>Acute & PICUs</p> <p>The Trust should review the windows in the entrance doors to the ward at Newbridge House as this could compromise patients' privacy and dignity.</p>	Please see attached document which details all ligature reduction works and environmental improvement works completed in response to this breach of regulation	Please see attached document	Please see attached document	XXXXRedactedXXXX	Completed

Unique Ref Number	Concern Raised	Actions Identified	Planned Completion Date	Actual Completion Date	Lead Individual	Status
	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Must Do Acute Care and PICUs The Trust must consider using mirrors on wards with multiple blind spots to mitigate against ligature risks to patients.</p>	Please see attached document which details all ligature reduction works and environmental improvement works completed in response to this breach of regulation	Please see attached document	Please see attached document	XXXXRedactedXXXX	Completed
LAP01	Local Concern - Ligature risk relating to doors	To trial the safe hinge Primera door in Eden PICU	May 2018 Trial Commencement	June 2018 was achieved for commencement of the trial	XXXXRedactedXXXX	Complete
LAP02	Local Concern - Ligature risk relating to en-suite bathroom doors	To trial the Kingsway door solution in Lavender ward	March 2019	March 2019 was achieved for commencement of the trial	XXXXRedactedXXXX	Complete
Actions taken March 2020 to 11 December 2020						
LAP03	Local Concern - The risk of bathroom en-suite doors as an anchor point for Ligature risks	To trial a new advanced product available on the market with door top and bottom alarm. Intastop door solution to be trialled at Mary Seacole ward 2 to assess roll out suitability as neither Kingsway nor	March 2020	Commencement of trial July 2020. Trial evaluated August 2020	XXXXRedactedXXXX	Complete

Unique Ref Number	Concern Raised	Actions Identified	Planned Completion Date	Actual Completion Date	Lead Individual	Status
		Primera options suitable for this environment due to construct of aged building		Delay due to COVID-19 wave 1 pandemic		
LAP04	The risk of bathroom en-suite doors as an anchor point for Ligature risks	Secure capital approval to proceed with roll out of Intastop door alarm system at Mary Seacole House	11 th June 2020	21 st August 2020 Delay due to trial of product – availability of financial envelope was confirmed 11 June	XXXXRedactedXXXX	Complete
LAP05	Inpatient Suicide Ward 2 27 th August 2020	Immediate 24 Hour review	27 th August 2020	27 th August 2020	XXXXRedactedXXXX	Complete
LAP05(1)	24 hour review action plan developed and approved including:- <ul style="list-style-type: none"> • Additional AHP Support • Additional Complimentary Therapies • Revised Ward Leadership • Review of Ligature Risk Assessment • Deployment of Psychological Support to support staff and enhance psychologically informed interventions and care planning • Reduction of bed capacity from 14 beds to 12 beds 		27 th August 2020	27 th August 2020	XXXXRedactedXXXX	Complete
LAP05 (2)	The risk of bathroom en-suite doors as an anchor point for Ligature risks	To commission and procure the intastop door alarm system for Mary Seacole Ward 2 en suite bathroom doors	31 August 2020	31 August 2020	XXXXRedactedXXXX	Complete

Unique Ref Number	Concern Raised	Actions Identified	Planned Completion Date	Actual Completion Date	Lead Individual	Status
LAP05(3)	The risk of bathroom en-suite doors as an anchor point for Ligature risks	Installation of the intastop door alarm system to en- suite bathroom of bedroom 13 on Mary Seacole ward 2	19 th October 2020	19 th October 2020	XXXXRedactedXXXX	Complete
LAP05(4)	The risk of bathroom en-suite doors as an anchor point for Ligature risks	Installation of the door alarm system to all 14 en- suite bathrooms on Mary Seacole ward 2	16 th November 2020	30 th November 2020 (due to manufacturing fault with alarm system)	XXXXRedactedXXXX	Complete
LAP06(1)	Receipt of letter from XXXXRedactedXXXX CQC relating to concerns about ligature risks in mental health inpatient wards	Assurance check to be undertaken against the CQC guide to inspectors for ligature risks & XXXXRedactedXXXX letter from August 2020 with report to Integrated Quality Committee	23 September 2020	23 September 2020	XXXXRedactedXXXX	Complete
LAP06(2)	Receipt of letter from XXXXRedactedXXXX relating to concerns about ligature risks in mental health inpatient wards	Development of physical environment improvement work stream and activate membership and improvement plan	28 September 2020	28 September 2020	XXXXRedactedXXXX	Complete
LAP06(3)	Receipt of letter from XXXXRedactedXXXX CQC relating to concerns about ligature risks in mental health inpatient wards	Complete an inpatient suicide cluster review in partnership with BSol CCG covering the period of 2013 and identify themes for improvement and action	30 September 2020	23 September 2020	XXXXRedactedXXXX	Complete

Unique Ref Number	Concern Raised	Actions Identified	Planned Completion Date	Actual Completion Date	Lead Individual	Status
LAP06(4)	Receipt of letter from XXXXRedactedXXXX relating to concerns about ligature risks in mental health inpatient wards	Complete review of all Ligature risk assessments for all inpatient wards to ensure compliance with CQC Brief Guide for Inspectors re Ligatures	30 September 2020	30 September 2020	XXXXRedactedXXXX	Complete
LAP06(5)	Receipt of letter from XXXXRedactedXXXX CQC relating to concerns about ligature risks in mental health inpatient wards	Issue patient safety alert to all staff on ligature risks associated with door anchor points	12 October 2020	12 October 2020	XXXXRedactedXXXX	Complete
LAP06(6)	Receipt of letter from XXXXRedactedXXXX CQC relating to concerns about ligature risks in mental health inpatient wards	Issue Patient Safety E Magazine to all staff with significant feature on Ligature Risks and findings of inpatient suicide cluster review	30 October 2020	30 October 2020	XXXXRedactedXXXX	Complete
LAP06(7)	Receipt of letter from XXXXRedactedXXXX CQC relating to concerns about ligature risks in mental health inpatient wards	Review of all outstanding works arising from ligature risk assessments & prioritisation programme	16 November 2020	16 November 2020	XXXXRedactedXXXX	Complete
LAP07(1)	Recommendation from the inpatient suicide cluster review	Identify four acute inpatient wards to pilot additional therapeutic activities to enhance therapeutic engagement of patients and agree	30 October 2020	30 October 2020	XXXXRedactedXXXX	Complete

Unique Ref Number	Concern Raised	Actions Identified	Planned Completion Date	Actual Completion Date	Lead Individual	Status
		implementation plan				
LAP08 (1)	Recommendation from learning from counterpart mental health nhs trusts	Complete scoping of remote technologies to enhance patient safety	30 November 2020	30 November 2020	XXXXRedactedXXXX	Complete
LAP09(1)	The risk of bathroom en-suite doors as an anchor point for Ligature risks	Complete prioritisation plan for roll out of door alarm systems across acute inpatient facilities and PICUs. Present Plan for costing.	30th November 2020	11th December 2020	XXXXRedactedXXXX	Complete
LAP09(2)	The risk of bathroom en-suite doors as an anchor point for Ligature risks	Complete costings of works scheduling programme for full extended roll out of door alarm systems across acute inpatient facilities and PICUs. (Follows preparation of prioritisation plan noted under LAP09(1))	11 th December 2020	11 th December 2020	XXXXRedactedXXXX	Complete
LAP10 (1)	Patients at the trust are not protected from the risk of self-harm because en-suite doors identified as ligature points have not been removed or sufficiently mitigated to ensure the safety of your patients. This places patients at significant risk of serious self-harm to	Develop schedule of interim mitigating actions to reduce risks of harm to patients whilst awaiting the roll out of door alarm systems across acute inpatient facilities and PICUs and submit for costings and works scheduling programme (see attached document detailing actions to be taken - submitted as additional evidence)	11 December 2020	11 December 2020	XXXXRedactedXXXX	Complete

Unique Ref Number	Concern Raised	Actions Identified	Planned Completion Date	Actual Completion Date	Lead Individual	Status
	their lives and safety.					
LAP09(3)	Patients at the trust are not protected from the risk of self-harm because ensuite doors identified as ligature points have not been removed or sufficiently mitigated to ensure the safety of your patients. This places patients at significant risk of serious self-harm to their lives and safety.	Approval to the final extended roll out plan for ligature door alarm solutions across all acute inpatient wards and PICU's including approval to capital allocation following completion of first phase (Mary Seacole Ward 2) November 2020.	23 December 2020	16 December 2020	XXXXRedactedXXXX	Trust Board meeting approved £2.5M to roll out door alarm system to all acute inpatient and PICU wards