



Birmingham and Solihull Mental Health NHS Foundation Trust  
Unit B1, Trust Headquarters  
50 Summerhill Road,  
Birmingham  
B1 3RB

XXXXRedactedXXXX

Inspection Manager  
Hospitals; Mental Health  
(Central West) Central Region  
XXXXRedactedXXXX

**31<sup>st</sup> March 2022**

Your reference: RGP1-10053519614  
Account number: RXT

Dear XXXXRedactedXXXX

**Re: 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 regulated activities  
Reporting schedule**

Condition 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.

Condition 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.

I am pleased to enclose for your attention our latest position relating to the implementation of the section 31 improvement plan for XXXXRedactedXXXX and for improving the safety of the physical environment.

Since our last submission to you, we have been continuing with work to strengthen our relational, procedural and environmental measures to improve patient safety. These actions focus on installation of the en-suite door alarm systems in our Acute Care inpatient settings, XXXXRedactedXXXX

Chair: Danielle Oum | Chief Executive: Roisín Fallon-Williams

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,our approach to ensure safe staffing given some of the ongoing challenges in this area  
XXXXRedactedXXXX.

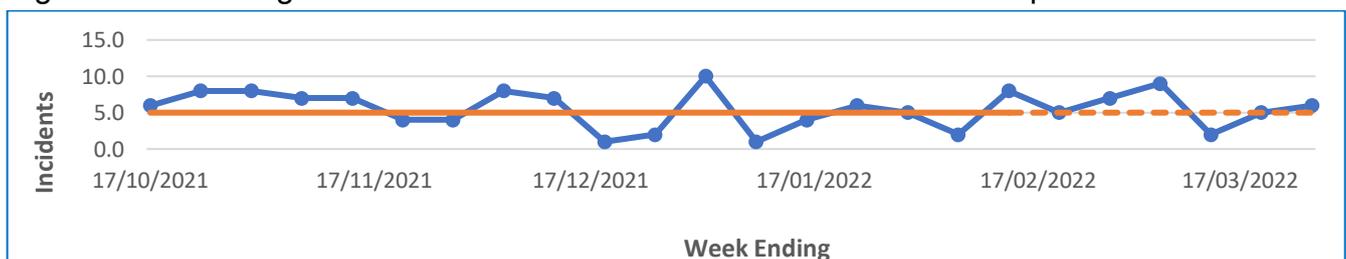
In terms of safer staffing, the Safer Staffing Lead Nurse has now been appointed. She has been meeting with the Clinical Nurse Managers, Matrons and Heads of Nursing for the inpatient areas of the Trust to discuss the support that her role can support with any future workforce planning. An example of this is consideration being given to the introduction of a Clinical Deputy Manager. We will be using QI methodology to implement this role into one of the areas in the Trust. If successful, we will look at options to scale up and spread. The post holder is also in the process of data gathering from each of the teams that use the E-rostering service. A clinical lead has also been allocated for the E-rostering project and we have started to explore the option of using 'Safecare'. Once this has been through our governance processes, we will look at piloting it. It is hopeful that we will be able to start using the MHOST in summer 2022.

As per previous updates, we have completed all en-suite door alarm systems in the north of the Trust ahead of schedule. However with an increase in national demand and some minor challenges with the PFI in the south of the Trust, we have had some delays in starting the works on these wards. It is expected that all en-suite doors on these wards will be installed by the end of June/ July 2022. The existing mitigations remain in place to support patient safety.

XXXXRedactedXXXX

We saw an initial decrease in the numbers of no anchor point incidents and then a slight increase towards the end of the reporting period. Measures being used to manage this risk continue to include, where there are service users with a presentation of high risk of self-harm, it is addressed by use of individual risk assessments, discussed in weekly MDTs, daily safety huddles and where beneficial in complex case reviews with a wider clinical membership to provide a more comprehensive approach to clinical safety.

Figure 2 –Actual Ligature Incidents with No Anchor Point in our Acute Inpatient Wards



All incidents were managed through relational and procedural controls. Such controls included:

- Risk formulation huddles have commenced on four wards (George, Tazetta, Eden PICU and MSH Ward 2) with positive feedback. These will also be rolled out in Assertive Outreach teams and Liaison Psychiatry teams within the next month.
- Daily safety huddles
- Psychology input
- Supporting service users with techniques to benefit longer term recovery and safety

- Medical Review and update to Care Plans and Risk Assessments
- 1:1 de-brief time between staff and patient
- Reducing Restrictive Practice QI Collaborative
- Therapeutic activities programme

Figure 3 – Actual Ligature Incidents with an Anchor Point in our Acute Inpatient Wards



There were a total of three anchor point incidents – two occurred in February and one in March.

The first incident took place on Saffron Ward at the Zinnia Centre on XXXXRedactedXXXX. While conducting therapeutic observations staff noticed that patient’s XXXXRedactedXXXX and he could not be seen. Staff entered the room and there was a XXXXRedactedXXXX. XXXXRedactedXXXX and patient was found with a ligature around his neck. Patient slumped to the floor, the ligature was removed and alarm raised. Patient was conscious eyes partially open and responding to voice however showed redness around XXXXRedactedXXXX neck. Patient was taken to general hospital and declared medically fit. On XXXXRedactedXXXX return to the ward he was nursed on level 3, 1:1 observations to minimise risk of further harm and/or suicide attempts. The incident was reported to the MDT and the patient’s treatment was amended to help patient with mental distress. Staff also had the opportunity to debrief with clinical psychologist and were also offered Trauma Risk Management (TRIM).

The second and third incidents involved the same patient on Melissa ward (we have reported other incidents for this patient in the last two submissions). They took place on XXXXRedactedXXXX and XXXXRedactedXXXX. On both occasions the patient was found during therapeutic observation, to have XXXXRedactedXXXX. Staff activated alarms and took patient’s weight. Responding staff members used ligature cutters to cut the ligature. The patient was given a 1:1 support following the incidents. XXXXRedactedXXXX was discussed in the daily safety huddle and her risk assessment was updated. A 72 hour review completed was also completed.

We welcome the opportunity to discuss any of these matters with you at our next meeting, however should you have any immediate queries or require any additional information then please do not hesitate to contact me.

Yours sincerely



**Sarah Bloomfield**  
**Executive Director of Quality and Safety (Chief Nurse)**