



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

24th December 2021

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 report to you and the implementation of our plan, we have been continuing with work to strengthen our relational and procedural and environmental measures to improve patient safety.

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

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XXXXRedactedXXXX improving our physical environment and discussions around safer staffing. We have now held a number of Safer Staffing Working groups and have discussed a number of possible initiatives to improve our staffing levels on our wards. MHOST training was delivered by NHSE/I on the 16th and 17th of December in two short sessions. The sessions were well attended by both clinical and workforce staff. The training has identified that we require a further session to enable the appropriate number of staff to be approved as suitable for checking the data for interrater reliability to ensure it is accurate. We are awaiting dates from the NHSE/I team who have advised that we do not proceed until this training is complete. We have also identified with NHSE/I that we would benefit from piloting the tool in a number of areas on the first set of data collection as opposed to completing for every inpatient area in the organisation.

We are committed to international recruitment but are also exploring other options such as recruitment of Nurse Associates and developing HCAs to complete their undergraduate training to support with the staffing issues. We are also working with HR to look at a 'retire and return' initiative to ensure the provision of pastoral support for newly qualified staff.

Work is ongoing with the installation of the en-suite door alarm system in Acute Care, with 7 wards now fully complete and operational. In preparation for Phase 2 of our environmental ligature reduction works, we have now installed a trial bedroom door system on Larimar Ward. The evaluation of the door installation was very positive and enabling works are taking place to allow the installation of these bedroom doors on the ward before the end of the financial year. Although there has been great progress with this project we are facing some delays with the South PFI (Oleaster and Zinnia) and with the exception of Caffra ward that was due for completion this month, the final completion dates remain on track. This is reflected in the Physical Environment action plan.

Broader ligature reduction works also continue on wards such as George Ward to improve the environment further and support service user safety.

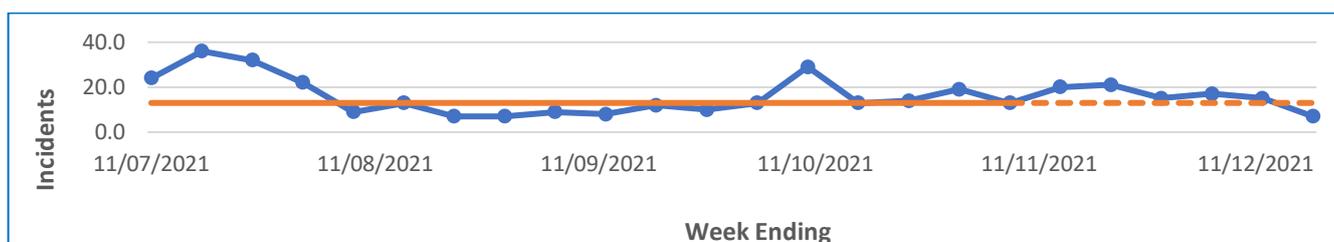
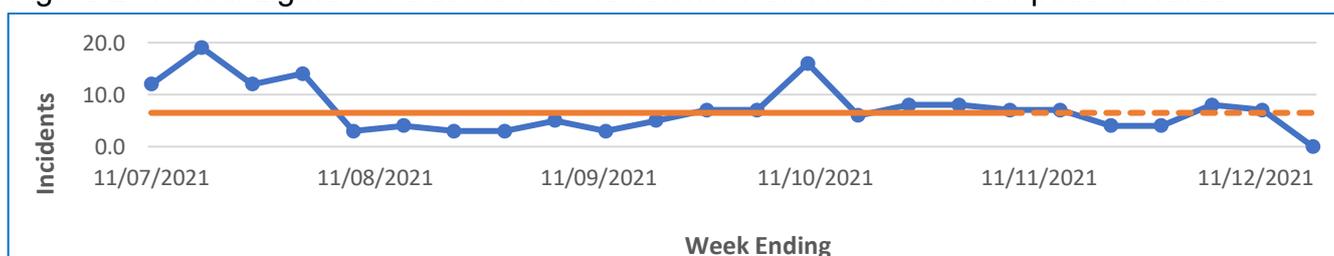


Figure 2 –Actual Ligature Incidents with No Anchor Point in our Acute Inpatient Wards

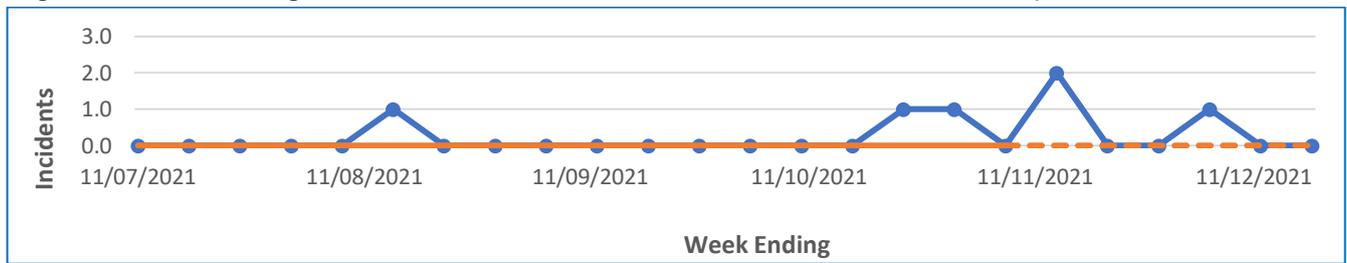


We also note a decrease in the number no anchor point incidents for the reporting period. These incidents continue to largely occur on our female wards such as Melissa, Larimar and

Eden Female PICU, and MSH Ward 2. All incidents were managed through relational and procedural controls. Such controls included:

- Risk formulation huddles commenced on four wards (George, Tazetta, Eden PICU and MSH Ward 2) with positive feedback.
- 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
- Safewards programme
- Therapeutic activities programme

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



We note one anchor point incident for the reporting period.

This occurred on the XXXXRedactedXXXX where an anchor point ligature incident was reported on Melissa Ward (female acute ward). During therapeutic observations patient was not visible through the window and staff could see the XXXXRedactedXXXX. Staff entered the room and patient had XXXXRedactedXXXX. Patient had XXXXRedactedXXXX. Alarms were raised and staff cut the ligature using ligature cutters. Due to the serious nature of the incident and historical risk patient was placed back on a level 3 observation to reduce risk and her personal behavioural plan was followed, which included removal of all personal items, she was also provided with anti-rip blankets. The on call doctor was contacted following which, it was advised that no further investigations or medical input was required. A debrief between the staff on shift occurred, and a follow up on wellbeing was provided by the manager. The SU has also completed a formal debrief.

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)