



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> August 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, our

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

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

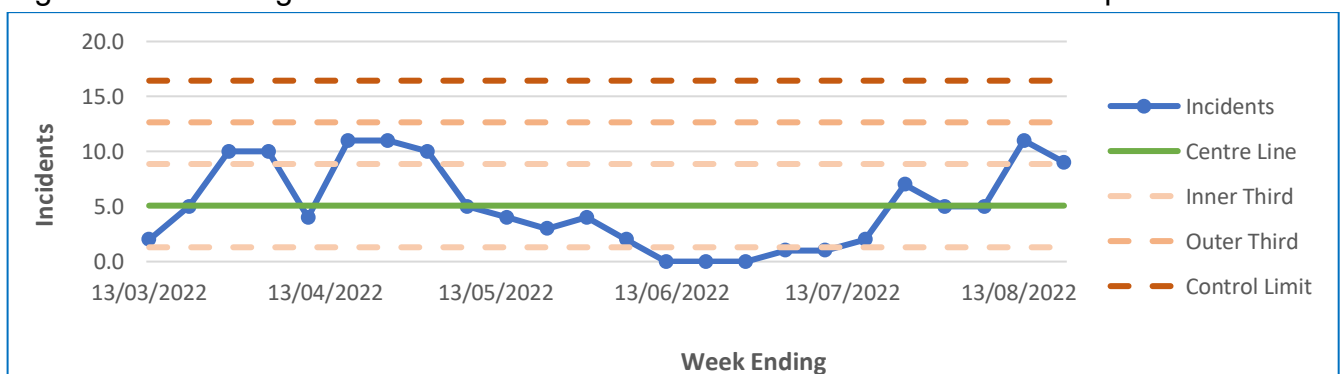
The revised door programme remains on track and in addition to the previously mentioned en-suite doors that have been installed in Acute Care, we have now installed all ensuite doors on Melissa, Japonica, Magnolia, Tazetta, Lavender and Saffron. The final connection to the Staff Assist System is underway through lifecycle PFI works across the two hospital sites (Oleaster and Zinnia) for the wards noted.

Following the focused inspection on Meadowcroft on June 13<sup>th</sup> and 14<sup>th</sup>, we are now in receipt of the draft report and have submitted the factual accuracy checks. We are continuing with our improvement works and our audits continue to show good compliance with areas around keys and security checks. We have also used the findings of the report to develop an assurance checklist to be used on our other wards to enable proactive learning.

There has also been an increase in the numbers of no anchor point incidents for the period, although again a slight decrease at the end of the 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. Risk formulation huddles are also being introduced across the service area.

XXXXRedactedXXXX

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

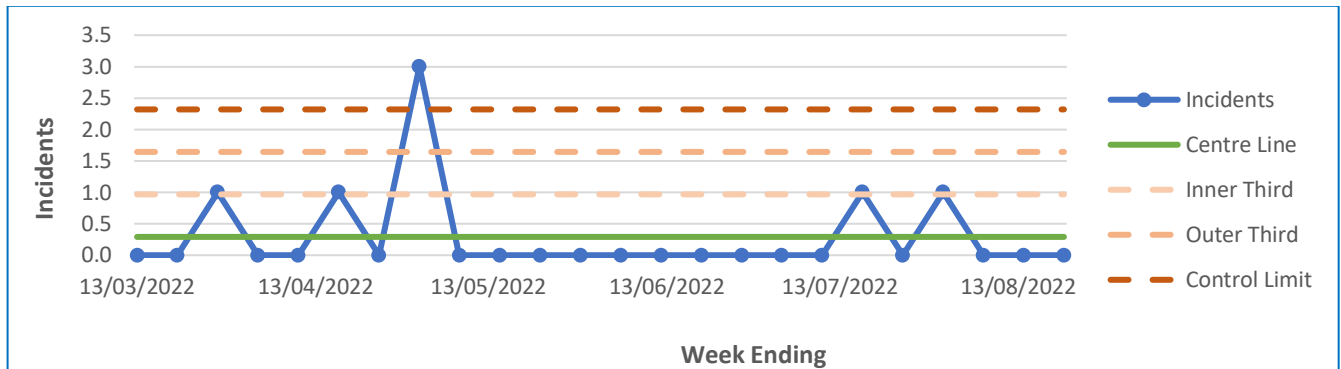


All incidents were managed through relational and procedural controls. Such controls included:

- Risk formulation huddles have commenced on four wards (George, Tazetta, Eden PICU and MSH Ward 2) and now in QEHB Liaison Psychiatry team.
- 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 Quality Improvement Collaborative
- Therapeutic activities programme

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



There was one anchor point incident in Acute Care since our last submission. This occurred on Newbridge House on XXXXRedactedXXXX. Patient A was seen trying to tie a ligature using a XXXXRedactedXXXX. Staff entered the room and set off their alarms. The patient was XXXXRedactedXXXX. The ligature was removed without the need for ligature cutters and staff emptied all items from XXXXRedactedXXXX room. The patient was supported by staff and XXXXRedactedXXXX risk assessment updated.

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

Sam

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