



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

28th February 2023

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 care planning and for improving the safety of the physical environment.

To ensure the ongoing safety of our service users and staff we have continued to implement, monitor and review a range of mitigations and supporting tools. These include the installation of the en-suite door alarm systems in Acute Care, ongoing audit and response for

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improvement in terms of XXXXRedactedXXXX, reviewing of staffing levels and implementing training, software and other measures to improve this.

XXXXRedactedXXXX

In terms of safer staffing, the MHOST data collection started on January 28th, 2023, this will be for a period of 28 days. This will start to form the establishment reviews across the services and before we make amendments to the establishments, as per guidance we will carry out a second MHOST data collection. This is planned for May 1st, 2023. The final report is anticipated to be finished by the end of June 2023.

Acute Care continues to have the pilot in the North patch, this continues to be successful with positive feedback from both staff and service users. We are aware Ward Managers continue to work clinically in the numbers to support the workforce.

The Lead Nurse for Safer Staffing is now part of a working group with the ICS specifically for retention. Necessary links are being made to share ideas of work that is being done to support with retention. There is now a working project group that we will be attending called the Workforce Planning Masterclass over a 19-week period with Health Education England. This will provide continued support with retention plans. We are also in the process of organising a recruitment and retention working group to provide further support within the Trust.

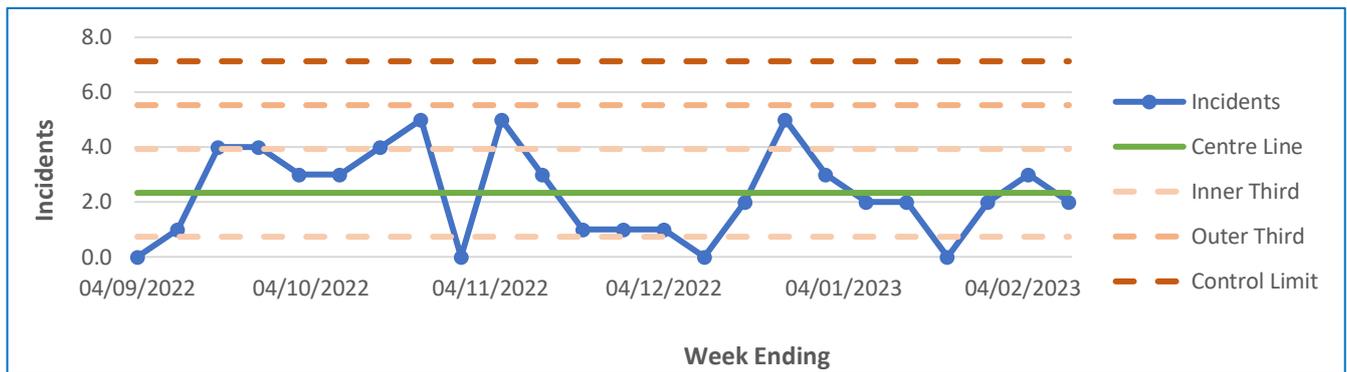
The Lead Nurse for Safer Staffing is also the lead for the Professional Nurse Advocate (PNA) role. There will be a standard operating procedure in place for this, with working supervision groups. Application forms are being collated ready for the September 2023 intake.

We have seen the arrival of the first international recruitment nurse. She has been in the country now for just over 2 weeks and is currently undertaking her OSCEs. She has met with her manager, colleagues on Japonica ward and has also spent time Clinical Educators who will provide ongoing support with other professionals. This will include pastoral support. We now have 36 nurses in the recruitment process, and we are expected to see the arrival of 5 of these nurses in March 2023.

The installation of the ensuite door alarm system in Acute Care is now complete. In terms of the broader physical environment agenda, we are continuing with the process of working with service areas to develop and finalise the capital programme for 2023/24. This will also include the prioritisation for the installation of the bedroom door alarm systems.

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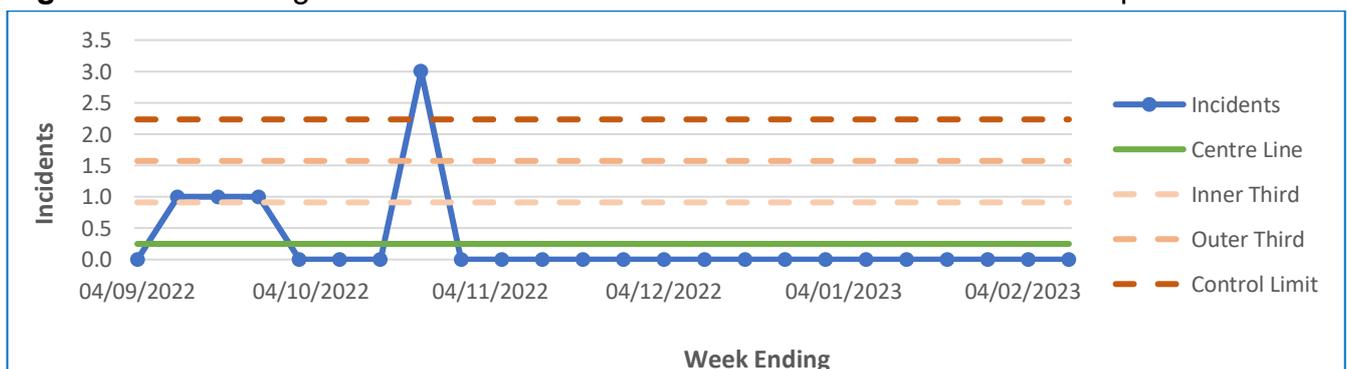
Figure 2 –Actual Ligature Incidents with No Anchor Point in our Acute Care Inpatient Wards



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
- Sensory wards project and improving the environment from a therapeutic perspective.
- Completion of in-depth sensory assessments – environmental assessments by Experts by Experience and checks by the relevant clinicians for the service user pathway.
- Support for patients with autism and learning disability in Home Treatment prior to admission.
- Reduction in the number of beds on Lavender ward from 16 to 14, with monthly touchpoint reviews to assess the position.

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



There were no anchor point incidents in Acute Care since our last submission.

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

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Steve Forsyth', with a stylized flourish at the end.

Steve Forsyth
Interim Executive Director of Quality and Safety (Chief Nurse)