



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> May 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,

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

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XXXXRedactedXXXX, our approach to ensure safe staffing given some of the ongoing challenges in this area XXXXRedactedXXXX. In terms of safer staffing, it is hopeful that we will be able to start the use of the MHOST tool in summer 2022. Training dates have been secured for the 23rd and 24th of May 2022. Following on from this training we will be using the MHOST tool to initially to pilot on a female and male ward at Zinnia Centre and Citrine and Tourmaline at Ardenleigh.

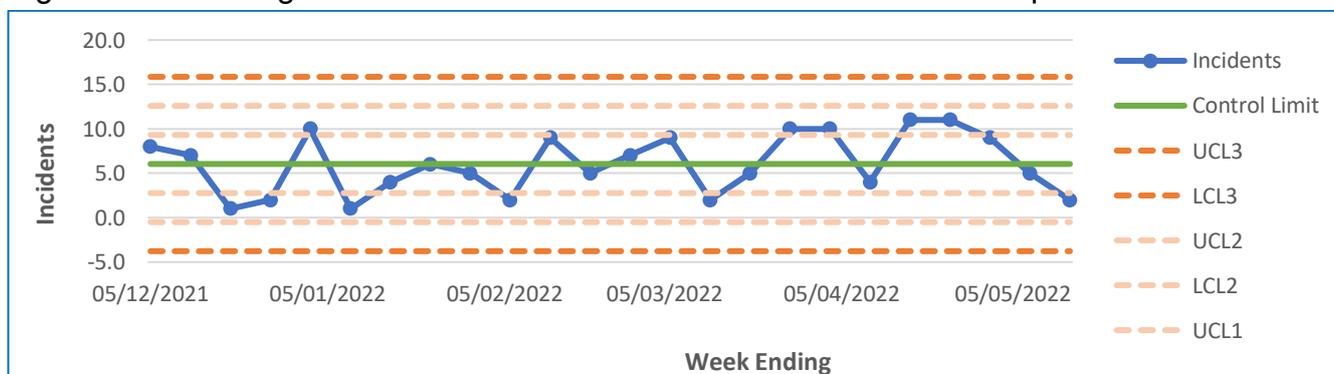
In addition to this we plan to pilot 'Safecare' as we previously mentioned and this was approved at our Safer Staffing Committee in May 2022 for implementation. The wards identified are our older adult wards at the Juniper Centre and Reservoir Court. This will start in June 2022 and we will be having weekly progress updates with the teams involved. We held a Workforce Planning and Transformation Workshop at the end of April. Linked to this, work is ongoing with key members of the organisation, and a series of workshops are planned to progress the principles and commitments that have been agreed. These include, clinical judgement-based establishment reviews prior to MHOST, improving the pipeline of newly qualified nurses and nurse associates.

As it relates to international recruitment, we are now linked up with Integrated Care System for nurses only and we are hopeful that we will recruit 30 nurses through this process. To ensure consistency in training and standards, we will be using the Objective Structured Clinical Exam process for mental health. We are hopeful that once we have recruited nurses they will be able to start in December 2022.

As per previous updates, we have completed all en-suite door alarm systems in the north of the Trust ahead of schedule. We are now in receipt of a revised programme which reflects the new dates for installation in the south, due to the challenges previously described. Installation of the en-suite doors commenced on Melissa ward at the beginning of May and should be finished by the end of the month. The existing mitigations remain in place to support patient safety. In addition to the above, we also have plans to complete the bedroom door alarm systems on two additional wards in the south by August 2022. We have included the revised door installation programme for these wards as part of this submission.

XXXXRedactedXXXX

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



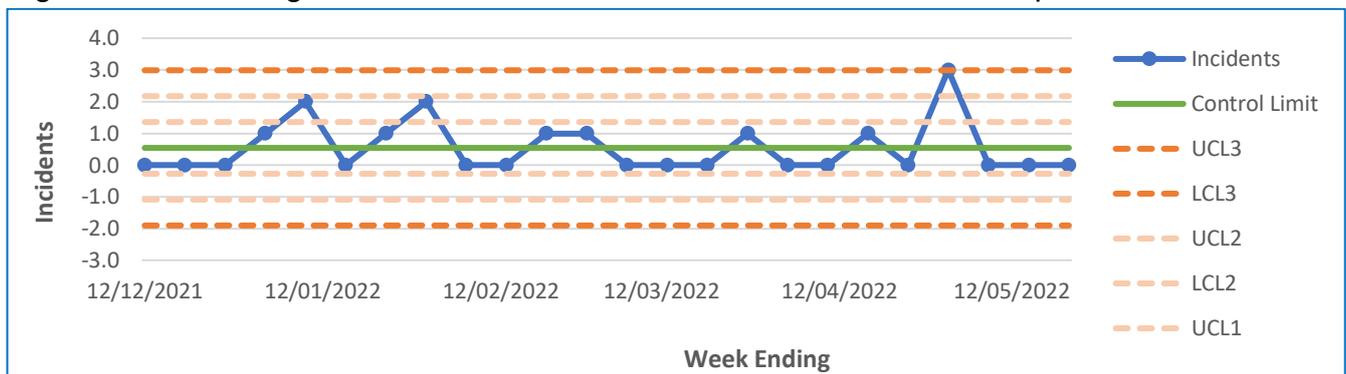
All incidents were managed through relational and procedural controls. Such controls included:

- Risk formulation huddles have commenced on four wards (George, Tazetta, Eden PICU and MSH Ward 2) and now in QEHB Liaison Psychiatry team The service is

currently exploring ways for recording the risk huddles in a similar way to safety huddles to enable consistency in monitoring.

- 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 two anchor point incidents since our last submission.

The first was on Melissa (female acute ward) on XXXXRedactedXXXX. This is the same patient as previously reported. The patient returned from leave anxious at 9.30pm, she engaged in a one to one with staff and accepted PRN lorazepam in early hours of the morning. She went to her bedroom to lie down after not being able to sleep the majority of the night and spending time in day areas with staff. During therapeutic observations patient was found to have tied a XXXXRedactedXXXX she had acquired the previous day and XXXXRedactedXXXX. Alarms were raised and staff responded. Ligature cutters were used to remove the ligature. Patient was sat on the floor when found and ligature was somewhat loose, observations were taken and all within normal range, there was no loss of consciousness, no discolouration to the face. Red mark observed on neck. Least restrictive management utilised and patient was supported with a one to one and was encouraged to spend time in the communal areas and the patient eventually agreed to do this.

The second incident was on Tazetta (male acute) on XXXXRedactedXXXX. While staff were completing therapeutic observations they noticed patient's XXXXRedactedXXXX was missing from his XXXXRedactedXXXX Patient had locked his bedroom door and was found in XXXXRedactedXXXX. The patient was XXXXRedactedXXXX and had the XXXXRedactedXXXX around his neck which XXXXRedactedXXXX when he was found. Staff pulled the alarm and patient tried to XXXXRedactedXXXX. Staff responded to the alarms and assisted with XXXXRedactedXXXX patient's neck. He was unharmed and the XXXXRedactedXXXX

removed. Patient sat on his bed where a staff member noticed blood dripping from his hand. He handed over to staff XXXXRedactedXXXX.

Patient reported to staff tearfully that he had been planning to kill himself all day, nothing in particular had happened and he reported that this is an accumulation of feelings which amounted to him tying the ligature. Patient reported that he would attempt to take his own life again.

Duty doctor was called who responded to assess patient and the wound. His cut was dressed and cleaned. His bedroom was stripped of anything which could be used to self harm. He was placed onto level 3, 1:1 therapeutic observations with no bathroom privacy due to the incident occurring in the bathroom. One to one was offered and XXXXRedactedXXXX

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)**