



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

**29<sup>th</sup> April 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 has been agreed to use QI methodology to implement the new role of Clinical Deputy Manager into two areas of the Trust. The Safer Staffing Lead Nurse is working with other Trusts to understand the benefits and improvements that were made on their mental health inpatient wards as a result of having this role in place.

It is hopeful that we will be able to start using the MHOST tool in summer 2022.

We still however plan to pilot 'Safecare' and this has been discussed at E-rostering committee and will also be discussed at our Operational Management Team meeting and our Safer Staffing Group.

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. In addition to the above, we also have plans to complete the bedroom door alarm systems on two wards in the south by August 2022.

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) 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 was one anchor point incident since our last submission, which occurred on George Ward (Male Acute) on XXXXRedactedXXXX. While staff were conducting the medication round, staff noticed a XXXXRedactedXXXX. Staff approached and the patient was found in his bedroom with a XXXXRedactedXXXX as a ligature around his neck. The alarms were activated and staff were able to remove the ligature without the use of a ligature cutter. He was conscious and he coughed. His physical observations were taken and they seemed to be within normal range. Oxygen was administered and the ambulance was called. The ambulance crew conducted their assessment and decided not to take the patient to hospital. They completed a discharge plan/summary. The Senior House Officers on the unit also completed their own assessments.

In response to the incident, the patient was given reassurance and reviewed in Ward Review. He was also moved closer to the nursing office and placed on level 3 observation. Staff were debriefed and were referred for TRiM.

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)**