



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

29th November 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 and some bedroom doors in the service, XXXXRedactedXXXX and opportunities to improve staffing shortfalls.

Chair: Phil Gayle | Chief Executive: Roisin Fallon-Williams

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In relation to our actions to address the current staffing challenges, we have now successfully recruited into 28 posts from international recruitment. We have also recruited an additional 8 RMN posts through attending a range of recruitment fairs.

We are developing a check and challenge process for our e-rostering system for all inpatient wards which will improve the monitoring of safe staffing levels prior to rosters being finalised and have robust clinical oversight. The expectation is that the new process will ensure that any concerns we have will be challenged and the necessary amendments made. This will provide assurance that our rotas are fair and safely staffed at the point of implementation. We are currently reviewing how we gain assurance around changes to rosters post finalisation and are planning to introduce a weekly 'look back' session which will be led by Divisional Heads of Nursing.

The current inpatient staffing establishment consists of RMNs, HCAs, Trainee Nurse Associates with the wider MDT consisting of Consultant Psychiatrists, Medical staff, AHPs and Psychologists. The Acute in-patient units are facing many challenges in relation to the recruitment and retention of staff, and this is having an impact on the ability to deliver quality interventions and we are aware that this reflects the national shortage of health care professionals. Currently the inpatient workforce are endeavouring to deliver all the interventions, however we have determined that there are other professionals with a skill that will have a positive impact in the ward environment and that adjusting the existing staff model to change how occupational therapy delivers their services will positively impact on the outcomes for service users. It was therefore agreed to pilot this model in four Acute Care inpatient wards - Eden Acute, Eden PICU, Larimar and George ward. The pilot has had positive feedback from both service users and staff across the four wards involved. There is consistent structure with groups and 1:1s available for the service users on the ward. The Pharmacy Technician allocated to the female wards has had her induction to the wards and we have a second Pharmacy Technician starting on the 5th of December 2022 providing input into the male wards. They have a structured timetable which will provide support to both service users and staff. This is aligned with our workforce plan which we submit to HEE and NHSE and have quarterly oversight meetings in place.

The revised door programme for the installation of the en-suite doors in Acute Care is now complete. The doors at the Zinnia have now been signed off and handover and took place w/c 21st of November. Melissa will be completed (connected) by November 30th with the remaining wards at the Oleaster being connected by December 14th.

In terms of the broader physical environment agenda, we have commenced 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.

XXXXRedactedXXXX

We have seen random variation with a decrease at the end of the reporting period for no anchor point incidents. 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 continue to be used across the service area.

We also have now agreed a specific Reducing Restrictive Practice plan for Acute Care, as the collaborative had seen real improvements in reducing these types of incidents on the wards where it was implemented.

In addition, the Personality Disorder Workgroup has developed a Trust Wide Framework for managing and working with service users with a personality disorder diagnosis. The framework includes support for staff and processes for decision making for complex cases and placements. If implemented this will support decisions for admission to acute wards, support whilst on acute wards, support for discharge and oversight of appropriate referral for speciality placements as indicated. Below is the structure of the framework.

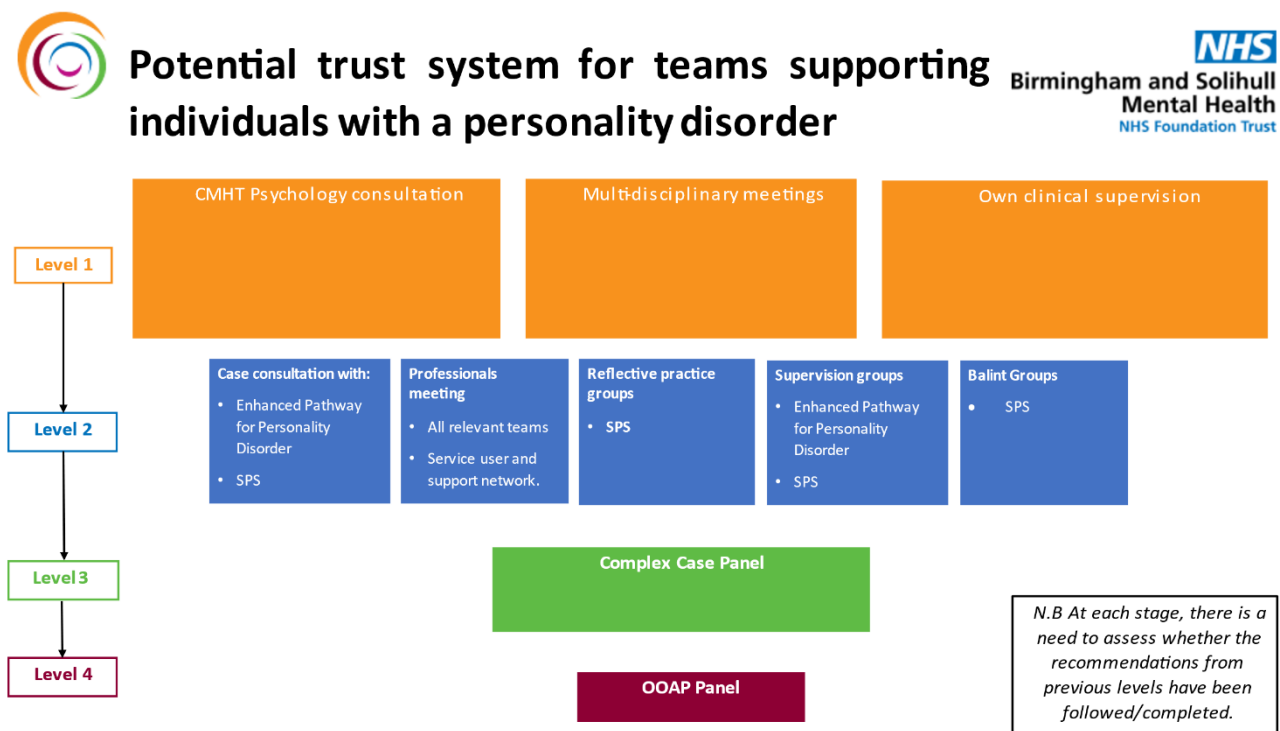
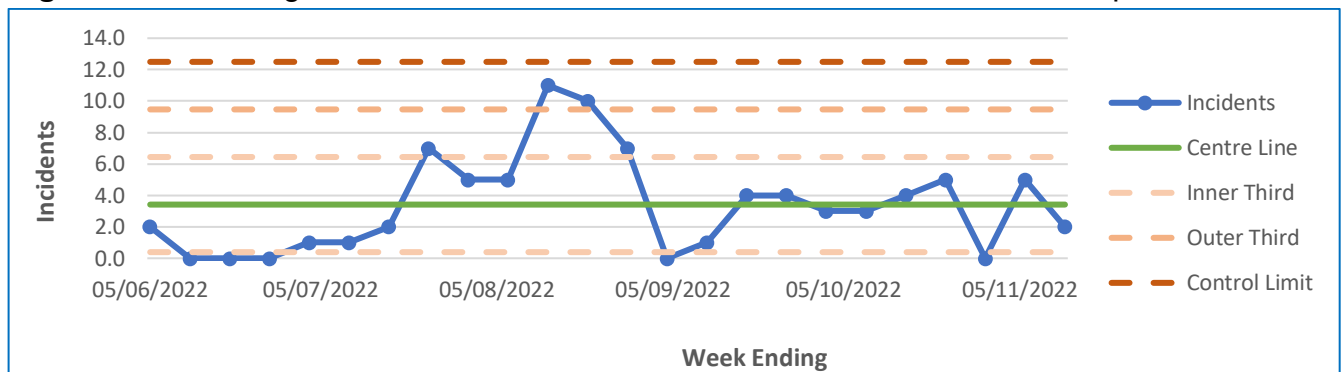


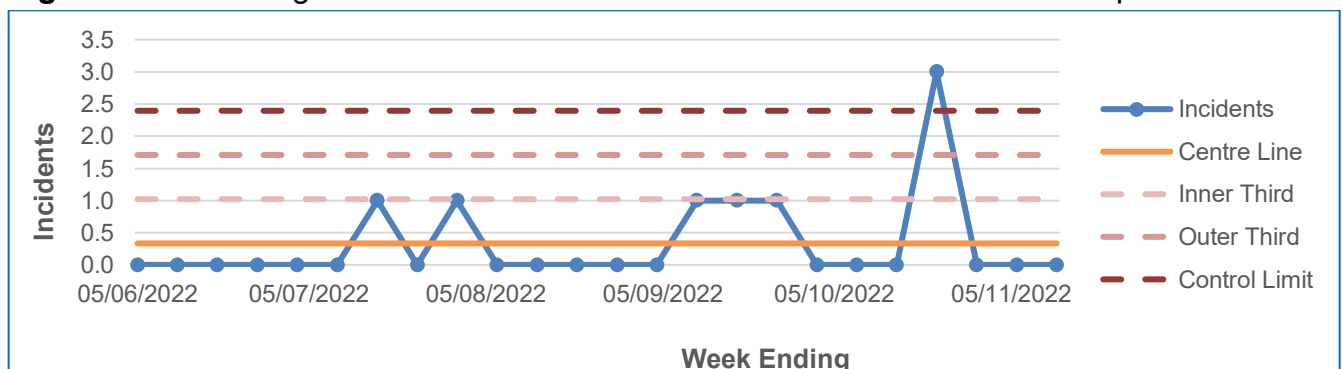
Figure 2 –Actual Ligature Incidents with No Anchor Point in our Acute Care Inpatient Wards



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.
- Two Band 7 Clinicians for out of hours to support clinical decision making

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,

Steve Forsyth

Interim Executive Director of Quality and Safety (Chief Nurse)