



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

**30<sup>th</sup> November 2021**

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 report to you and the implementation of our plan, we have been continuing with work to strengthen our relational and procedural measures to improve patient safety. This

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

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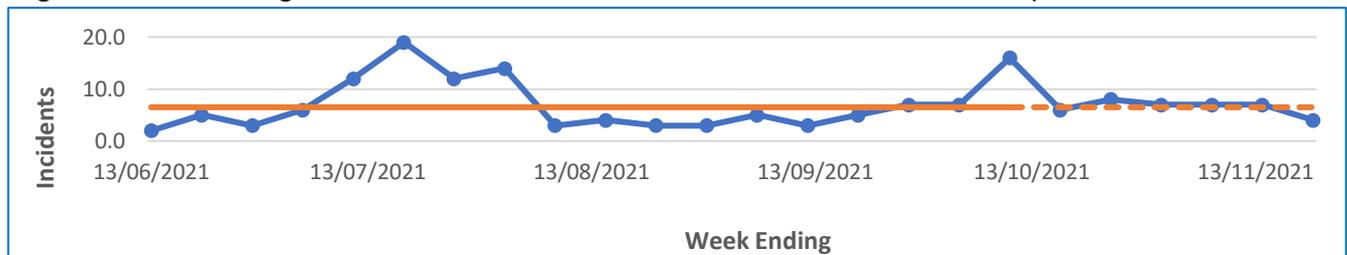


XXXXRedactedXXXX and discussions around safer staffing. We have now established a Safer Staffing Working group to bring greater focus on what is required to improve the ongoing staffing issues on our wards. This will include the use of the roll out of the MHOST scoring tool in the near future.

Work is ongoing with the installation of the en-suite door alarm system in Acute Care, with 7 wards now fully complete and operational. In preparation for Phase 2 of our environmental ligature reduction works, we have now installed a trial bedroom door system on Larimar Ward. The trial will be evelauted at the end of November to determine if it will deliver all the requirements in terms of ligature risk management and access control.

After meeting with all interested parties, we have now also completed the long list for our 3 to 5 year capital programme as it relates to the installation of products and designs to reduce the risk of ligatures in the physical environments. The list will be prioritised by risk levels based on the capital envelope for each financial year.

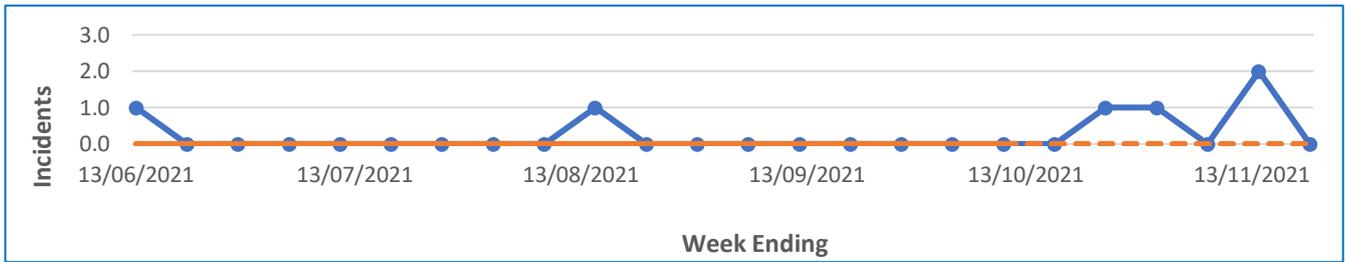
Figure 2 –Actual Ligature Incidents with No Anchor Point in our Acute Inpatient Wards



We note a relatively stable picture for the number of no anchor point incidents with a decrease towards the end of the reporting period. These incidents continue to largely occur on our female wards such as Melissa, Larimar and Eden Female PICU, and MSH Ward 2. All incidents were managed through relational and procedural controls. Such controls included:

- Risk formulation huddles
- 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 Collborative
- Safewards programme
- Therapeutic activities programme
- Developing sensory friendly ward project

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



We note two anchor point incidents for the reporting period.

The first occurred on Eden Acute (male ward), where a service user reported that he had attempted to utilise a XXXXRedactedXXXX both as a ligature and an anchor point but the XXXXRedactedXXXX. Details from the 72 hour report, detail that there wasn't any evidence of ligature marks around his neck and as the XXXXRedactedXXXX are weight-bearing anti-ligature products it is not likely that the XXXXRedactedXXXX. However the service user was supported to spend the remainder of the night in the communal areas so that he could be monitored. He agreed to this and he later reported to feel a lot calmer, he accessed PRN Promethazine and slept well.

The second occurred on the XXXXRedactedXXXX where an anchor point ligature incident was reported on Melissa Ward (female acute ward). This was investigated locally and an initial management review was completed on the XXXXRedactedXXXX identifying positive practice in relation to staff exercising good clinical judgement in this case. The risk assessment was reviewed the previous day with identification of suicide risk and 15 minute observation set. The observing staff member registered some concern when completing the observation prior to the incident and returned within five minutes. This situational assessment enabled the early detection of the incident and the fact that this was resolved without any physical harm coming to the patient.

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)**