



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

**28<sup>th</sup> April 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 XXXXRedactedXXXX 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, XXXXRedactedXXXX, reviewing of staffing levels and implementing training, software and other measures to improve this.

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

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XXXXRedactedXXXX as well as completed the installation of all the en-suite doors in Acute Care. XXXXRedactedXXXX. On this basis we are seeking clarification on the continuance of the Section 31 notice and the requirement for ongoing monthly submissions.

XXXXRedactedXXXX

In relation to staffing, our second Internationally Educated Nurse (IEN) sat her OSCE exam in April. We have also had two additional IEN nurses and they have been allocated to Acute and Secure Care respectively. It is anticipated that by the end of November 2023 we will have 33 IEN nurses working across the four inpatient divisions.

The Fundamentals of Safer Staffing e-learning module has now launched on e-Learning for Healthcare. This has been circulated to the Heads of Nursing and AHPs for completion and cascading to their service areas for completion also. *“The e-learning provides an overview of the essential components required for nursing or midwifery staff planning, known as establishment setting. It introduces the main principles, underpinning policy context, and key considerations; and it also describes the links with patient safety and quality care, staff deployment and what good governance looks like.”*

A Check and Challenge meeting is being piloted at the Oleaster and Ardenleigh sites. This will start week commencing 1<sup>st</sup> May 2023. This will feed back into Safer Staffing meetings quarterly.

Whilst not related to Acute Care, we are planning to implement a buddying system for staff who are new to our organisation, and we will be piloting this in two of our hard to recruit areas. We are going to adopt similar processes that other organisations have done to support those we appoint from the day of appointment. This will support with the transition into our organisation and will also provide the support that is needed when in post.

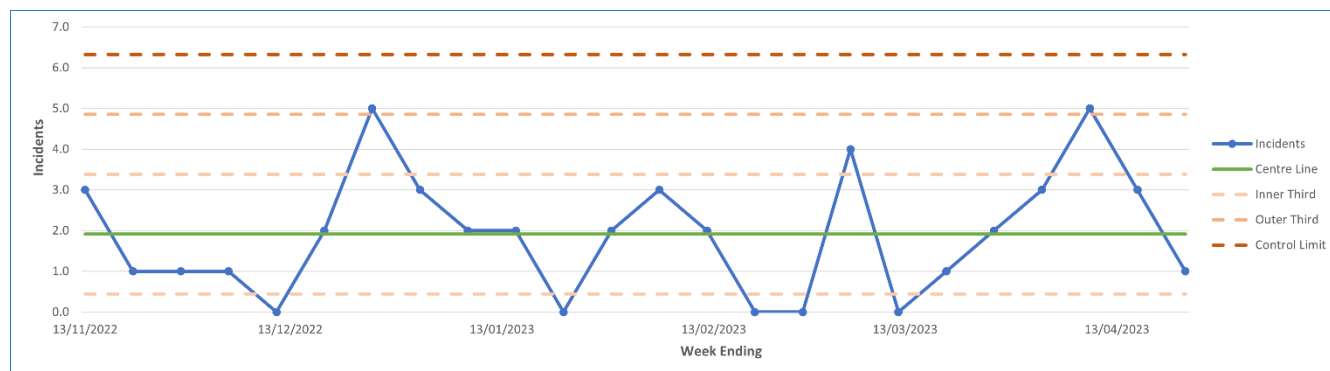
The installation of the ensuite door alarm system in Acute Care is now complete. In terms of the broader physical environment agenda, in collaboration with the service areas, Estates colleagues and the Chief Operating Officer we have now finalised the capital programme for 2023/24. This includes the prioritisation for the installation of the bedroom door alarm systems. Additionally, there are some ongoing internal discussions regarding the most suitable anti-barricade system to be used on these.

XXXXRedactedXXXX

We have also seen random variation for the reporting period for no anchor point incidents, again with most data points above the median with a reduction at the end of the period. This is noted to be as a result of a few complex patients on our female acute and PICU wards such as Eden PICU, Lavender and Melissa where there have been high levels of self-harm incidents and the appropriate levels of interventions and observations have been put in place

to manage the situations. These patients require PICUs but unfortunately are being managed on our acute wards due to lack of capacity on PICU wards.

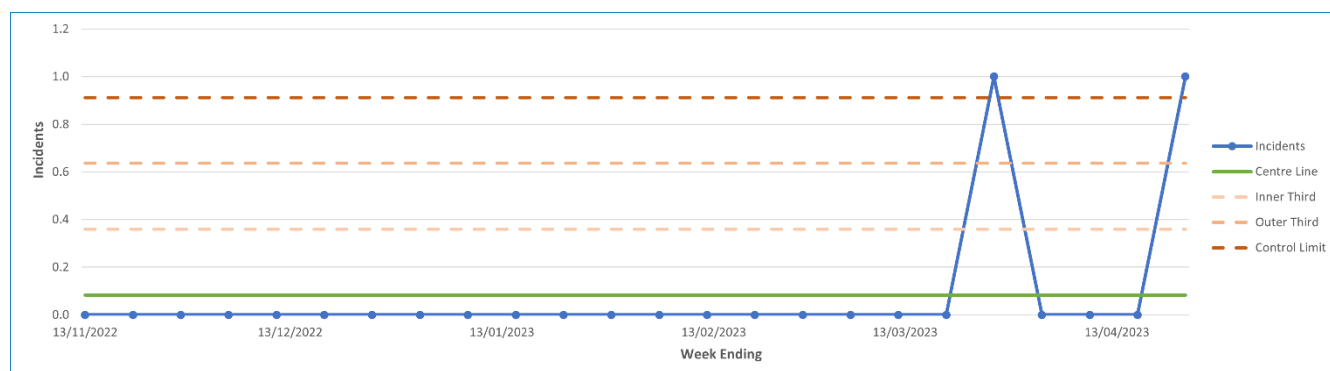
**Figure 2** –Actual Ligature Incidents with No Anchor Point in our Acute Care Inpatient Wards



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.

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



In the first incident, a patient had tied a ligature and attempted to XXXXRedactedXXXX, at which point the en-suite door alarm was activated. Staff attended immediately and patient was safely removed from the ligature. Following this incident, a one to one was undertaken with the patient and they were placed on level 3 observations which was agreed with the service user. The patient's risk management tool was updated, and the Duty Doctor attended the ward. Following the incident, the patient was noted to have minor redness to the neck but no further injury.

In relation to the second anchor point incident, a patient had XXXXRedactedXXXX. Staff on observations noted patient sitting on floor with ligature tied around neck, raised alarms instantly and the XXXXRedactedXXXX by the staff immediately. Discussion was held with the patient and agreed to increase observations to level 3, the risk assessment tool was updated. There were no physical or visible injuries to the patient.

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)**