



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

28th February 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, XXXXRedactedXXXX and

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

Customer Relations | Mon – Fri, 8am – 6pm
Tel: 0800 953 0045 | Text: 07985 883 509
Email: bsmhft.customerrelations@nhs.net
Website: www.bsmhft.nhs.uk

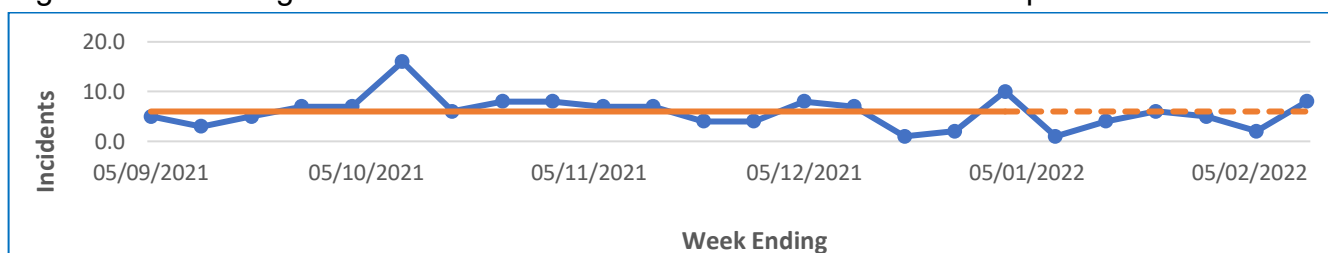


our response to gaps identified, our approach to ensure safe staffing given some of the ongoing challenges in this area and XXXXRedactedXXXX.

In terms of safer staffing, we are still awaiting support from the Chief Nursing Officer Safer Staffing fellows, to enable changes to be made so that we can pilot the MHOST tool to support with some of our staffing challenges.

Works continue to deliver the physical environment programme on schedule and we will be commencing the installation of the bedroom door alarm system on Larimar this month.

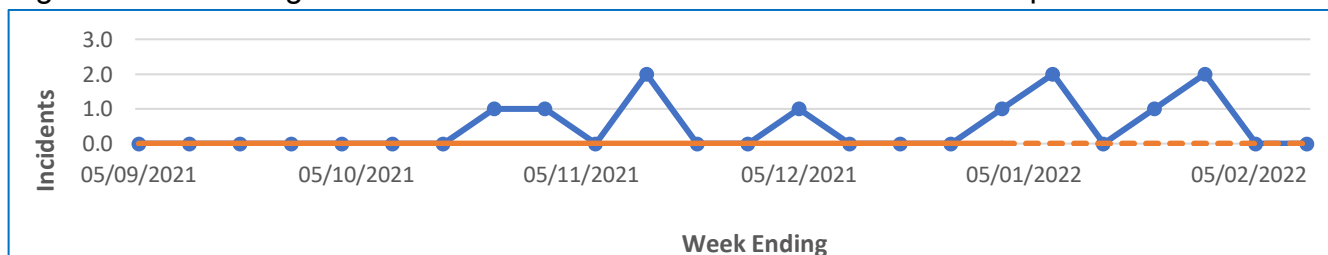
Figure 2 –Actual Ligature Incidents with No Anchor Point in our Acute Inpatient Wards



We also note a decrease in the number no anchor point incidents for 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 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
- Safewards programme
- Therapeutic activities programme

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



We note three anchor point incidents for the reporting period, two of which occurred on Melissa Ward and one on Meadowcroft.

The incidents on Melissa took place on XXXXRedactedXXXX and involved the same service user. In the incident on XXXXRedactedXXXX, the patient was found with a XXXXRedactedXXXX. Alarms were raised and the ligature was XXXXRedactedXXXX and removed from her neck. The patient was supported on 1:1, and encouraged to spend time out of her bedroom to which she complied. Talk down and de-escalation were utilised to support her.

In the second incident on XXXXRedactedXXXX, the patient was found with a ligature on XXXXRedactedXXXX. Staff activated their alarm and released the ligature by opening XXXXRedactedXXXX and ligature cutters were used to cut the ligature from around the neck. All property was removed from her room and support was given to her. She was also seen by the duty doctor. On both occasions the service user's risk assessment was updated and her observation adjusted as required.

The above two incidents were referred to in the total of 5 detailed for Melissa Ward to in our last submission. The service user is also receiving support from her consultant, two psychologists and Personality Disorder psychology supervision.

The incident on Meadowcroft took place on XXXXRedactedXXXX, where the service user XXXXRedactedXXXX. Staff were able to remove the ligature and provided support to the service user.

All of the above incidents have been subject to a 72 hour review by the Patient Safety team and the findings discussed with the clinical teams for implementation.

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)