



Birmingham and Solihull Mental Health NHS Foundation Trust
Unit B1, Trust Headquarters
50 Summerhill Road,
Birmingham

XXXXRedactedXXXX

Inspection Manager
Hospitals; Mental Health
(Central West) Central Region
XXXXRedactedXXXX

30th April 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.

We would like to bring your attention to one action where we have needed to extend the deadline to ensure we maintain safety for our service users.

XXXXRedactedXXXX

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

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Since our last report to you and the implementation of our plan, we have or are establishing a number of controls to strengthen the leadership in Acute Care services. We recognise that strong leadership and governance are central to the safety of care that we deliver in our inpatient wards, as are consistency of professional standards. We have therefore:

- Advertised a new senior clinical leadership role 'Head of Nursing and AHPs' for acute care. This role will be a new role creating triumvirate leadership across the service area with a particular emphasis on quality and safety and professional standards. We initially interviewed for this post on 30 April 2021 however we failed to appoint a suitable candidate. This was the right decision on the day as it is crucially important that we appoint the right professional with the right skills and experience. We are therefore re-advertising the post with immediate effect both internally and externally and have interviews planned for 14 May 2021.
- Appointed an Executive Director of Quality and Safety on our Trust Board (Chief Nurse) Sarah Bloomfield. This individual is highly credible with significant experience of professional nursing leadership, professional practice, executive Director of Nursing experience, leadership experience and CQC experience. One of Sarah's specific tasks is to review our overall approach to safety and improvement including the specific action plan associated with section 31.
- Our Executive Director of Quality and Safety (Chief Nurse) has already established a number of professional networks and forums both internally and externally. These will begin meeting in the new format in May 2021 and include establishment of ward manager meetings with Sarah enabling direct professional leadership and professional practice standards and support. A Matrons Forum has been refreshed to the same effect enabling increased professional grip and professional leadership
- We have put in place a Clinical Educator role as an additional post within acute care. The Clinical Educator provides ongoing direct support to frontline clinical staff ensuring ongoing education in clinical risk assessment, care planning, clinical record keeping and observation practice. This individual helps frontline staff to understand the expected standards of care and provides a direct professional conduit between the Deputy Director of Nursing and frontline staff.

The lead for all of the above actions is Sarah Bloomfield, Executive Director of Quality and Safety (Chief Nurse).

Whilst recognising that our Section 31 improvement plan is set out over a period of time we have started to see some positivity around a journey of improvement with a 50% reduction of ligature incidents and incidents of self harm in our acute inpatient units. We recognise that we still have further improvement to make and this letter along with our existing section 31 improvement plan gives detail of additional steps that we are taking.

In light of the recent unexpected death on George Ward, we are actively reviewing our timeline for the roll out of the en-suite door alarm system to all of our Acute Care wards and

Reservoir Court to determine whether it is at all possible to expedite these works. We will have concluded this work by week commencing 17th May 2021 at which stage we will be able to confirm any opportunities to pull forward planned works. The door alarm system has now been installed on the en-suite door on George Ward, with sign off planned for week commencing May 3rd. This work has been completed in advance of the schedule submitted to you previously.

We have sought further independent expert advice on controls (relational, procedural and physical) that have proved effective in other mental health trusts in managing ligature risk. This has included seeking advice from the Lead Mental Health Nurse at NHS England. Following the death of XXXXRedactedXXXX, our Integrated Quality Committee commissioned our Clinical Governance Committee to conduct a holistic safety review of our acute inpatient wards. This is being conducted with multi disciplinary involvement and independent expertise and scrutiny, to determine where we can strengthen relational, procedural and physical controls. Such controls will include safe staffing levels and skill mix, therapeutic observation practice and the physical environment. This will include minimisation of ligature risks and will also consider other environmental risks of self harm. The independent expertise and scrutiny has been secured from our Clinical Commissioning Group and the Quality and Safety Team at NHSE. The results of this review will be presented to our Integrated Quality Committee on 19 May 2021.

XXXXRedactedXXXX

Safety of our physical environment continues to feature XXXXRedactedXXXX and this week this was evident when clinical decisions were taken in response to a damaged seclusion suite and the ongoing safe care of the service user.

XXXXRedactedXXXX

We would also draw your attention to the table below which shows a reduction in incidents of self harm and ligature in our Acute inpatient units since we commenced the deployment of our existing section 31 Improvement Plan as follows. The one anchor point incident in April utilised the service XXXXRedactedXXXX and the XXXXRedactedXXXX but was safely managed. The use of a ligature cutter was not required and there was no harm to the service user. One to one time was given to the service user, verbal de-escalation was used and the bedroom was stripped to remove potential items of ligature. Agreement was reached with the service user that he could retain his XXXXRedactedXXXX as this was one of his protective factors. Staff did not feel that this warranted enhanced observation as it was an isolated incident and no further incidents were reported.

Month 2021	All incidents of actual self harm	Of which are ligatures with no anchor point	Of which are ligatures with an anchor point
Jan	87	34	0
Feb	33	16	0
March	37	16	1
April to date	38	7	1

Whilst we are proud of the way that our colleagues have engaged in our improvement plan, we recognise that some colleagues need more help in maintaining the consistent application of these changes so that we can be confident that they are embedded in day to day practice. This is a particular area of focus for us moving forward, along with a strengthened approach to assurance testing which also measures the impact that the changes are having on the safety temperature of our inpatient wards.

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

A handwritten signature in black ink, appearing to read 'SB', written in a cursive style.

Sarah Bloomfield
Interim Executive Director of Quality and Safety (Chief Nurse)