



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 October 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.
XXXXRedactedXXXX

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

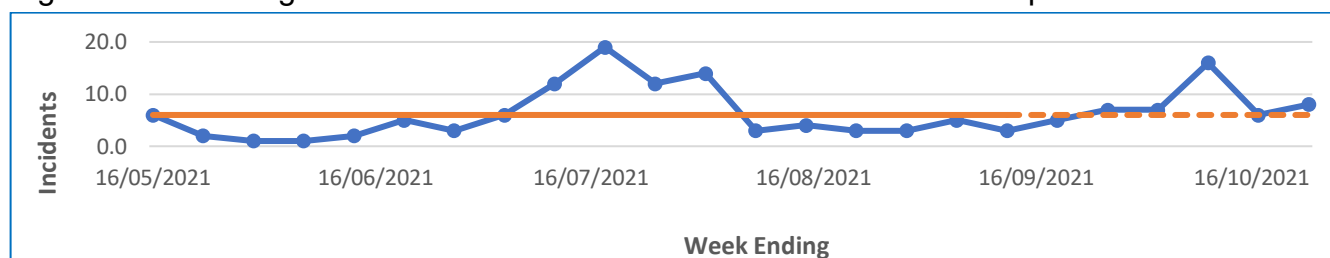
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XXXXRedactedXXXX and discussions around safer staffing. We have now established a Safer Staffing Working group to bring greater focus on what is required to improve the ongoing staffing issues on our wards. Work is ongoing with the installation of 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 reduced ligature works, we are also in the process of installing a door monitoring alarm system for the bedrooms as a trial on Larimar (November 1st) to assure ourselves that it will deliver all the requirements in terms of ligature risk management and access control.

XXXXRedactedXXXX

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



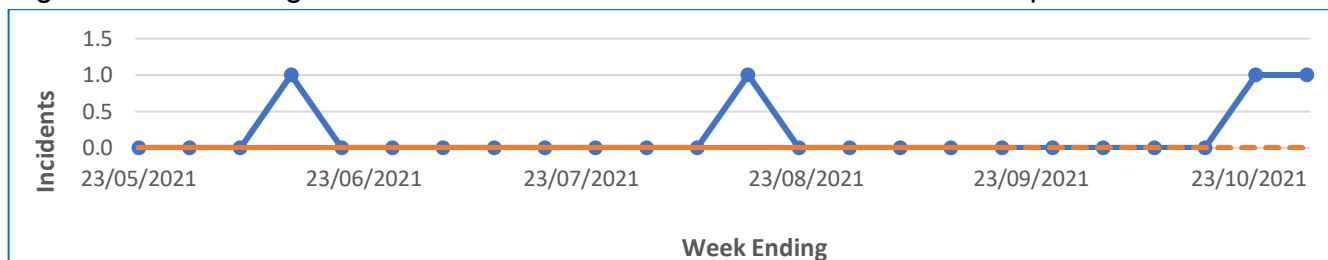
We note a relatively stable picture for the number of no anchor point incidents with a spike in early October, then a decrease the following week but the incidents appear to be on the rise again for the last week of the reporting period. These incidents continue to largely occur on our female wards such as Melissa, Larimar and Eden Female PICU, and ward 2 although we have started to note a small number of these incidents on a few of our male wards such as Tazetta and Caffra. 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 Collaborative
- Safewards programme
- Therapeutic activities programme
- Developing sensory friendly ward project

However there was one no anchor point incident on Mary Seacole House Ward 2 resulting in the service user attending hospital for further monitoring. The service user was found by staff on her ensuite floor with a ligature around her neck. This was removed using ligature cutters and her physical observations taken by staff. Oxygen levels were reduced slightly at this and her saturations then dropped. Paramedics arrived and took over care of patient. Patient was escorted to hospital via ambulance along with a member of staff. No specific injuries were

recorded, all physical observations were within normal range and the service user was transferred back to ward the same day. She was supported following the incident with MDT review with her, psychology input, dietetics input for eating disorder and she was accepted for PICU on the XXXXRedactedXXXX

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



Unfortunately, despite all the efforts of staff and the improvements that we continue to strive to make, since our last submission, we have had two incidents utilising an anchor point, both involving the service user's XXXXRedactedXXXX.

The first incident was on Newbridge House on the XXXXRedactedXXXX, where the service user tied a ligature using XXXXRedactedXXXX around her neck and then over her XXXXRedactedXXXX. The ligature was removed and medical assistance and monitoring were provided to her by staff until the paramedics arrived. The service user experienced seizures during this time, diazepam was administered and the seizures stopped. She was transferred to hospital for a CT scan following attendance of the paramedics. No other specific injuries were recorded and she returned to the ward the next day, where her risk assessment was updated. She was transferred to Melissa suite on the XXXXRedactedXXXX and has since had a couple of consultant reviews, OT intervention – Behavioural Management Plan and traffic lights and a post incident debrief.

The second incident occurred on George Ward on the XXXXRedactedXXXX. The service user was in his bedroom and when staff took his medication to him there, they found a XXXXRedactedXXXX tied around the door. The staff forced entry and found the service user suspended from the door using his XXXXRedactedXXXX. These were removed without the need of a ligature cutter. Service user was assessed and monitored and found to have C-spine tenderness, headache and reduced sensation over his face and a brief period of unconsciousness. He was subsequently transferred to hospital, where he had a CT scan, ECG, bloods were taken, MRI and X-ray and found to have displaced a cartilage in his neck. He returned to the ward the same day, where there was an MDT review and he had psychology input.

These incidents will be investigated as part of our Serious Incident process.

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 grey ink, appearing to read 'SBloomfield', written in a cursive style.

Sarah Bloomfield

Executive Director of Quality and Safety (Chief Nurse)