



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

31st January 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

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door alarm systems in Acute Care, XXXXRedactedXXXX reviewing of staffing levels and implementing training, software and other measures to improve this.

XXXXRedactedXXXX

As it relates to safer staffing and our activities to improve that, following the MHOST training session hosted by NHS England in December 2020, the Lead Nurse for Safer Staffing was informed that the Trust had met requirement for the the number of staff needed to be trained in order to implement this into practice. Training has been provided to each of our service areas. The lead nurse will continue to roll out additional training sessions across the service areas.

The MHOST data collection will start on the 30th January 2023 for a period of 28 days this will form part of the establishment review across the inpatient wards.

We continue to actively recruit into vacancies on the wards. We will be attending a national recruitment event on the 8th March 2023 and we hope to be as successful as we have been at previous events.

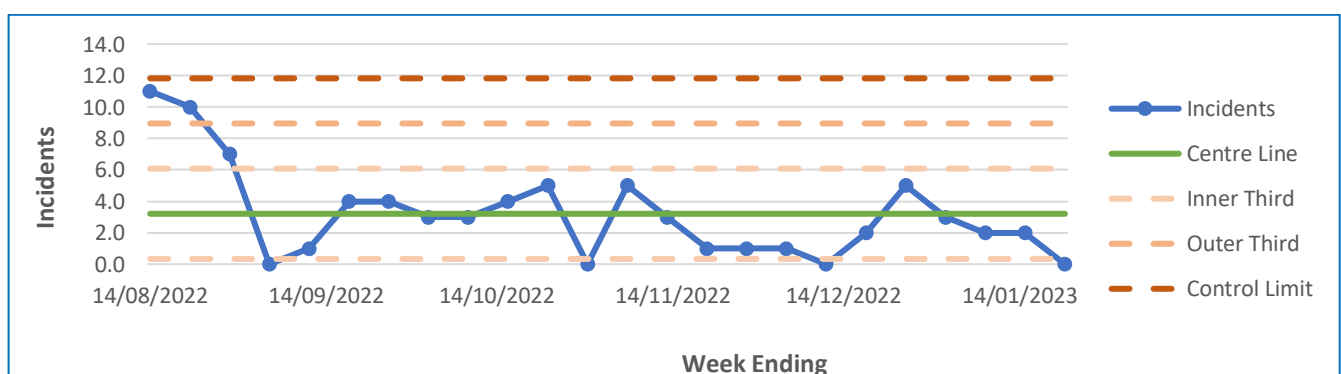
The pilot in the North Acute services continues to be successful, we receive regular positive feedback from service users and staff on the wards.

The installation of the ensuite door alarm system in Acute Care is now complete. In terms of the broader physical environment agenda, we are continuing with the process of working with service areas to develop and finalise the capital programme for 2023/24. This will also include the prioritisation for the installation of the bedroom door alarm systems.

During our audit processes, we have identified an issue with the locking mechanism on the current bedroom doors however the installation of the new Kingsway door monitoring alarm systems in phase 2 of the installation process will resolve this issue.

XXXXRedactedXXXX

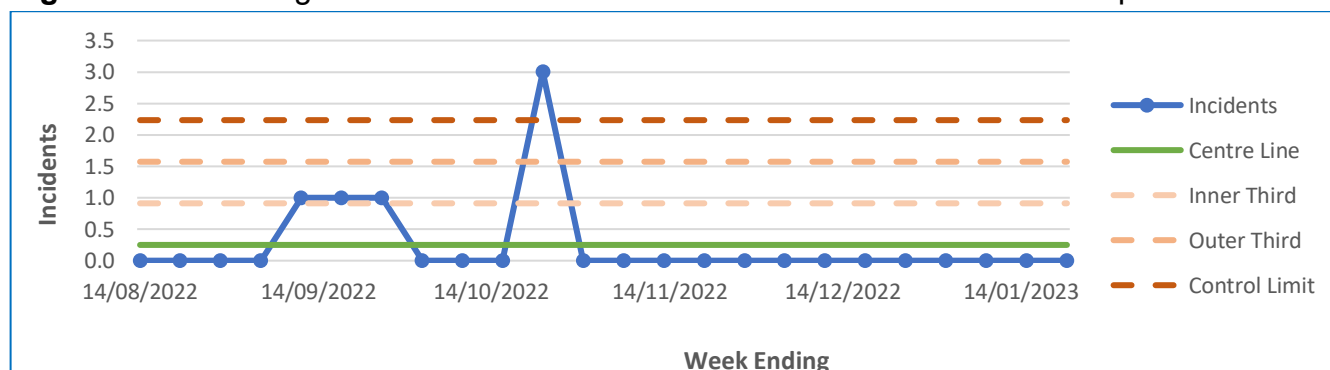
Figure 2 –Actual Ligature Incidents with No Anchor Point in our Acute Care Inpatient Wards



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.
- Reduction in the number of beds on Lavender ward from 16 to 14, with monthly touchpoint reviews to assess the position.

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



There were no anchor point incidents in Acute Care since our last submission.

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)