U

Leicestershire Partnership NHS Trust

Public Trust Board 29th June 2021

Ligature Risks Annual Report

Purpose of the Report

This report presents of a summary of the ligature risks and improvement work within Leicestershire Partnership Trust (LPT). The report;

- Outlines the management and oversight of ligature risks including environmental fixed point ligatures for Leicestershire Partnership NHS Trust.
- Highlights where gaps in assurance have been identified and improvement action taken to address these.
- Provides an update on the prioritisation programme of work in respect of fixed point ligatures. A proposal has been submitted to the capital group for allocation of funding and resources to support the reduction in fixed point ligature risk trust wide
- Outlines the improvement priority relating to ligatures and self harm within the Quality Account 2021-2022

Analysis of the issue

- In August 2020, Dr Kevin Cleary, Deputy Chief Inspector of Mental Health and Community Services wrote to all Mental Health Trusts setting out the concerns of the quality and safety of care in mental health units. More specifically, this letter highlighted the expectation for Trusts to address known environment fixed point ligatures through a prioritised capital programme of work.
- A benchmarking and gap analysis exercise was undertaken following receipt of the letter using the Care Quality Commission (CQC) briefing note v5 March 2020 relating to ligatures alongside the published letter from Dr Kevin Cleary. As a result, the trust Ligature Reduction Group was established in October 2020 to monitor the management of ligature risks trust wide. The finding was presented at the first meeting of the Ligature Reduction Group on the 5th October 2020 for agreement of the actions identified. This culminated in the development of a trust wide action plan
- Governance arrangements for the monitoring and management of environmental fixed point ligatures is through the operational Ligature Reduction Group reporting jointly into Patient Safety & Experience Group and the Health & Safety Committee for oversight

Overview of key findings of review, gap analysis and improvement actions

This section summarises the key information in regards to the review and gap analysis work in relation to both fixed and non fixed ligatures. Furthermore, it outlines improvement work underway or planned.

Environmental fixed point ligatures

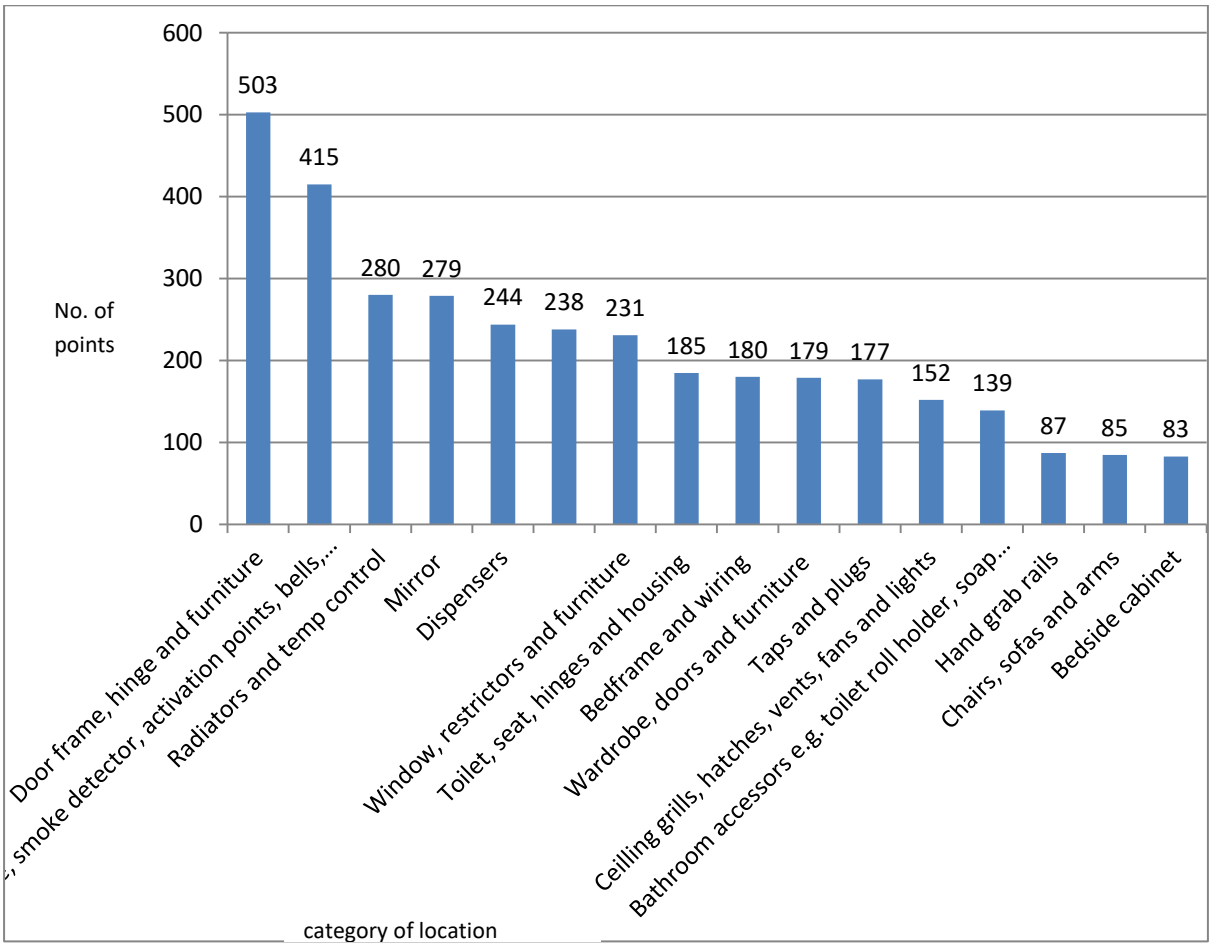
Local assessments were carried out to identify the number of fixed point ligatures using the LPT Environmental Ligature Risk Tool (an adapted tool based on the Manchester Risk Tool) Chart 1 shows the numbers of fixed point ligatures as identified through these local assessments. The Ligature Reduction Group have prioritised the following 3 risks for capital expenditure to reduce risk:

(1) Door frame, hinge and door furniture. There are no retro fit of doors recommended to meet fire regulations available which also ensure vision panels are in line with CQC expectations and promote privacy and dignity.

(2) Window restrictions and window furniture.

(3) Bedside cabinets

Chart 1: Chart to show the number of fixed point ligatures as identified by the LPT Environmental Ligature Risk Tool



- ‘At a glance boards’ displaying areas on the ward identified as high and low risk of ligatures are in place in all AMH and LD wards.
- Preventative maintenance arrangements are established for testing anti-ligature items – for example, curtain rails
- Community Hospital wards now have ligature cutters available in the resuscitation trollies on all wards. Ward staff are expected to undertake ligature training on the use of the cutters and can contact Matrons in the Mental Health Directorate to discuss patient risk assessments and care plans.
- Work has progressed and amendments have being made to the LPT Environmental Ligature Risk Tool (an adapted tool based on the Manchester Risk Tool) and wards have been audited using the new tool. The findings are reported to the Ligature Reduction Group and Health and Safety group and appropriate action taken to mitigate identified risk e.g alert issued to the wider trust, remedial action through estates or replacement through capital work. Environmental scans, which include monitoring of identified ligature points and the general ward environment, to improve the quality and safety, are undertaken and reported on a weekly checklist by the ward staff. The environmental ligature risk assessment is reviewed annually unless anything changes in the ward/environment, then it is updated immediately.
- The review and consistency checking of ligature risk assessments and management strategies in Community Mental Health Teams and in clinic areas which are not owned by LPT continues and is part of the Ligature Reduction Group work plan for 2021.
- A new electronic based ligature awareness training for clinical staff was developed and is due to be available as an e-learning module on Ulearn for clinical staff. Compliance will be monitored through the Ligature reduction Group.
- A review of the ligature risk areas and estates response and capital programme for ligature works required has commenced using a prioritisation formula looking at the patient group, learning from incidents and the access and ability to carry out the works safely.

Incident Analysis of reported ligature between January 2019 and March 2021

- Between these dates there were 2,286 reported incidents of ligature in inpatient and community settings, of these 2,209 involved non fixed ligatures, for example clothing, string, yarn/thread, plastic.
- 77 incidents were recorded involving a fixed point ligature (1 was a duplicate incident).
- Of these 77 incidents, 37 were wrongly coded as fixed point and 6 of these 37 incidents involved fixed ligature points in the community.
- There were therefore 33 incidents that involved a fixed point item within inpatient settings as detailed below:

Table 1 Incidents of fixed point ligatures

Ligature point	Number of incidents
Involving doors excluding door handles	15
Door handles	2
Window fittings	2
Curtain poles/fittings	2
Ward landlines/phones	2
Beds	2
Toilet tissue holders	2
Toilet seat	1
Radiator	1
Bedside furniture	1
Wall panel/furniture	1
Chairs	1
Fan	1
Total	33

The Ligature Reduction Group is focusing on 6 areas of improvement and has developed an improvement plan detailing the work required:

1. Ligature Policy Review – the review undertaken has resulted in a new Management of Fixed Point Ligature Policy awaiting final sign off by the trust.
2. Monitoring and review of environmental ligature risk assessment
3. Training updated to include e-learning and the use of ligature cutters
4. Prioritisation of capital programme works for doors, widow fittings and bedside furniture, exploring new technology.
5. Sharing learning from incidents and implementing change by developing a culture of learning through review of incidents, national guidance and alerts associated with fixed ligatures.
6. Working with the Trust Self Harm Group to build on the minimisation of non fixed ligature incidents with a reduction of harm to the patient

- Bedrooms and ensuite doors were ranked as the main area to focus on. Through review of incidents and clinical discussions with the relevant team, the group reached the decision to remove ensuite doors in Acute Mental Health inpatient settings whilst maintaining privacy and dignity.

- The Trust is currently exploring the use of staff alert doors that include anti-ligature alarm methodology and an anti-barricade function. A trial has taken place and staff have been given the opportunity to give their feedback to the Ligature Reduction Group

- The Health & Safety team have devised a ligature e-learning session and the Trust is developing face to face training regarding the use of ligature cutters.

Non Fixed ligatures

Non fixed ligature incidents make up the majority of ligature related incidents within Leicestershire Partnership Trust. Therefore, ensuring we have a clear approach to prevent, reduce harm and support patients and staff with incidents involving non fixed ligatures is of significant importance. Therefore this improvement is identified as a key priority within the Quality Account 2021-22, (Priority One). This aims to improve the quality of care to individuals at risk of self -harm in inpatient setting and build on the minimisation of non fixed ligature incidents. The Quality Account details the delivery expectations in each quarter and the programme of work.

Proposal

In summary the key ongoing priorities for quality improvement are:

- Ensuring organisation wide learning and further embed the work of the Ligature Reduction Group to reduce the number of ligature incidents across the Trust
- Promoting a safe and secure environment in which to treat our patients and improve their experience
- Reducing the number of environmental fixed point ligatures across the Trust through the capital work programme over a three to five year period.
- Delivering the work as outlined within the Quality Account 2021-2022

Decision required

This paper provides assurance on the identified risks and improvement work that is in progress to support the reduction and management of both fixed and non fixed ligatures trust wide. The Trust Board is asked to receive the report for information and assurance.

Governance table

For Board and Board Committees:	Public Trust Board 29th June 2021	
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Zayad Saumtally, Michelle Churchard (Head of Nursing) & Bernadette Keavney (Head of Trust Health and Safety Compliance)	
Date submitted:	18/06/2021	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	N/A	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	Assurance of the ligature improvement work is monitored through quality forum	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	One off	
STEP up to GREAT strategic alignment*:	High **S**tandards	x
	Transformation	
	Environments	x
	Patient Involvement	x
	Well **G**overned	x
	Single Patient **R**ecord	
	Equality, Leadership, Culture	x
	Access to Services	
	Trust Wide Quality Improvement	x
Organisational Risk Register considerations:	List risk number and title of risk	1 and 3
Is the decision required consistent with LPT's risk appetite:	yes	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	yes	
Equality considerations:	yes	