NHS
Sheffield Health and Social Care
NHS Foundation Trust

Policy: NP 043 Ligature Anchor Point and Blind Spot Risk Assessment Policy (inc. procedure)

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Policy author/ leads	Patient Safety Specialist Clinical Risk and Patient Safety Advisor

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Policy Version and advice on document history, availability, and storage
The previous 'Ligature and Blind Spot Risk Reduction Policy [inc. procedure] (MD003 v4 Oct 2019' has been reviewed and rewritten. This is version 2 of the new policy and replaces all previous versions.

This policy will be available to all staff via the Sheffield Health & Social Care NHS Foundation Trust Trust's website. The previous version will be removed from the Intranet and Trust website and archived. Word and PDF copies of the current and the previous version of this policy are available via the Director of Corporate Governance.

This policy should not be available publicly according to this National Patient Safety Alert.

MH ligature policies NatPSA March 2020 (

Any printed copies of the previous version should be destroyed and if a hard copy is required, it should be replaced.

Keywords	Ligature, blind spot, risk, reduction, environmental, suicide, Clinical Review.

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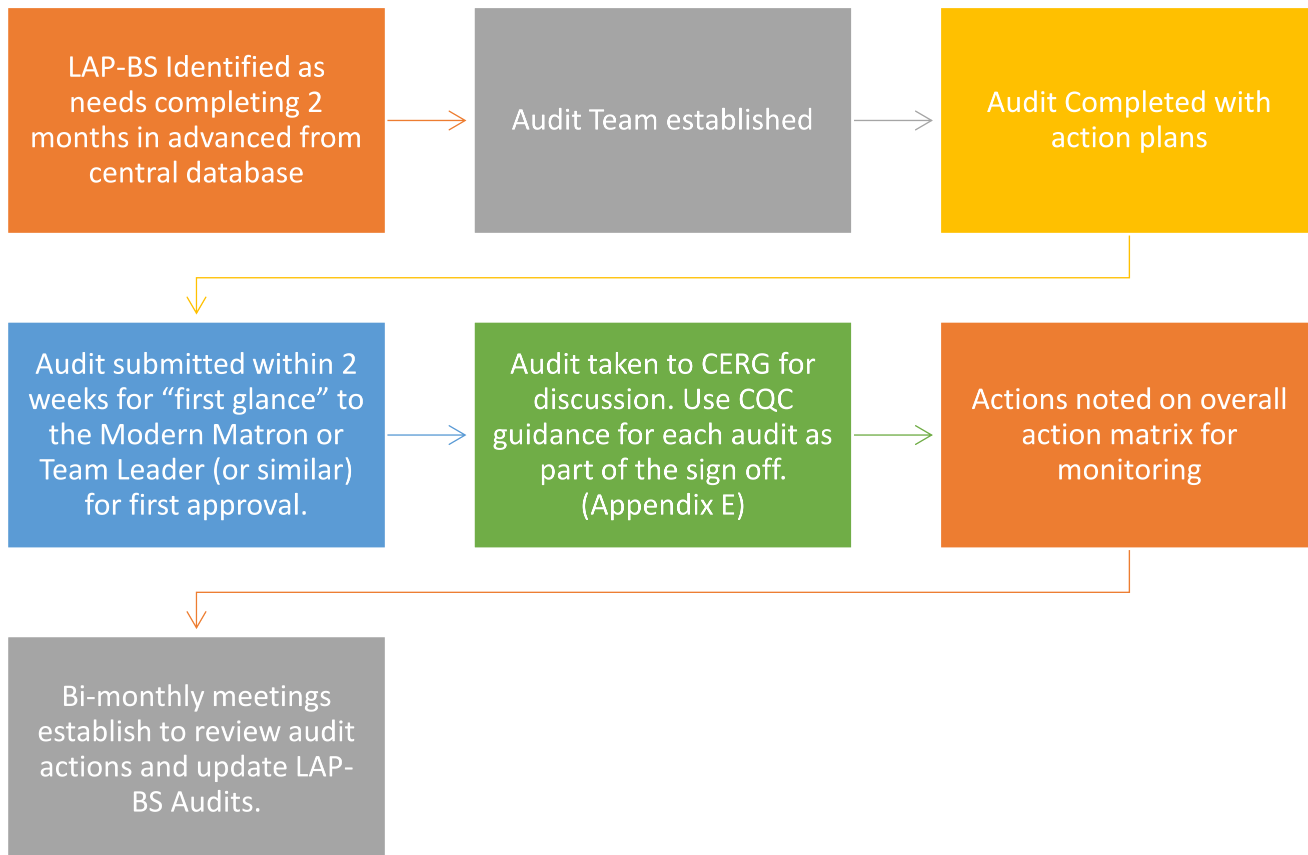
Ligature Anchor Point & Blind Spot (LAP-BS) Assessment Process



1. Introduction

Hanging remains the commonest method of suicide for mental health patients/service users, whether in an in-patient setting or in the community. (NCISH, 2022).

Ligation without an anchor point can also lead to death through asphyxiation. Removal of all items by which ligation can take place is impossible. Clinical risk assessment and attention to environmental and clinical factors is therefore paramount on inpatient mental health units.

An **obvious ligature anchor point** would present a significant risk and because of the risk, the National Suicide Prevention Strategy for England (DoH 2002) sets the standard that **likely** ligature anchor points in mental health service inpatient environments **must be removed, substituted for an anti-ligature product, or covered.**

Risk assessment must consider the balance of the patient group and the likelihood of harm e.g., grab rails in elderly unit or disability accessible rooms. In such cases a balance should be sought between the relative risks involved. Mitigation plans must be made where ligature anchor points remain, and all staff must be made aware of these plans and adhere to them.

The European Convention on Human Rights – Article 2 (the Right to Life) includes the obligation to take positive steps to prevent suicide in both informal/voluntary and

detained patients when there is a ‘real and immediate risk’ of suicide which is known or should have been known (*Savage v South East Essex Partnership NHS FT* [2008] UKHL 74; *Rabone v Pennine Care NHS FT* [2012] UKSC 2).

The risk would be deemed to be real and immediate if it appeared in a risk assessment. Therefore, in such circumstances, there is a duty to take positive measures to preserve life, including increased observation, restricting access to higher-risk areas or higher risk items, preventing the person from leaving the ward and utilizing holding powers if deemed necessary. Note that the absence from the ward of an informal/voluntary service user at real and immediate risk of suicide should be managed as though s/he is detained (Rabone v Pennine Care NHS FT (2012) UKSC 2)

2. Definitions

2.1 Ligature anchor point (LAP) – A ligature anchor point is any point which is load bearing (for the purposes of this policy able to support over 40 kg) that can be used to tie or secure a ligature that can be used as a means of hanging.

2.2 Ligature (noun) - any item that when placed around the neck can restrict the airway. The item can be used with a ligature anchor point or independently.

2.3 Ligate (verb) - to use an item placed around the neck to restrict the airway with the intention of causing bodily self-harm.

2.1 Anti-ligature fitting - any fitting that is designed in such a way as to reduce the likelihood a ligature being attached to it and should:

- cause the ligature to slip off, or
- break away from its mount when placed under pressure of weight.

2.2 Anti-ligature curtain systems – are either rails designed to collapse, or curtains designed to break away from a fixed rail when a load of 40Kg or more is applied in accordance with manufacturer’s instructions. The Trust standard is magnetic curtain tracking designed to break at a maximum load of 40kg.

2.3 Ligature cutters – are purpose specific items for cutting ligatures. They must not be used for any other purpose than dealing with emergency situations involving ligatures.

2.4 Risk assessment - a careful examination of what in the practice and areas could cause harm to people or the organization so that the individual or organization can weight up whether they have taken enough precautions, or they should do more.

2.5 Independent Ligature Assessor – an independent ligature assessor is an individual not substantively employed in the area being assessed and will not be familiar with the area being assessed.

2.6 Blind spot – an area where the observation of a person is obstructed.

3. Purpose and Scope of the Policy

3.1 This policy applies to all inpatient settings (including ward gardens), inpatient therapy areas, residential units and outpatient/community premises where patients access a service within the Trust. It does not apply to publicly accessible outside areas of Trust sites.

3.2 The Policy aims to ensure that the appropriate level of clinical and operational management of ligature risk is assessed and overseen for the safety of patients/service users and prevention of suicide; that appropriate technical advice is sought, and action taken regarding the specification of anti-ligature fixtures and fittings within the specific environment.

3.3 The responsibility for direct implementation of this policy is with the Clinical Directorate: Heads of Service, Heads of Nursing, General Managers/Matrons and Ward/Team Managers.

3.4 This policy outlines the roles and responsibilities of staff groups to ensure that ligature anchor points are identified, managed (through removal, mitigation or ongoing clinical management) and reviewed at regular intervals through an agreed standardised assessment and management policy on behalf of SHSC. Reporting on the process and associated risks will be required at Quality Assurance Committee.

3.5 This policy should be read in conjunction with the associated Standard Operating Procedures which detail the assessment process: ‘Guidance on the Ligature Anchor Point Audit Assessment Procedure - Inpatient Ward and Residential Homes and the Guidance on the Ligature Anchor Point Audit Assessment Procedure: Non-Inpatient Ward Settings.

3.6 **It is vitally important that all staff know that it will not be possible to eliminate all potential ligature anchor points and have a completely ligature free room**. Ligature anchor point risks will remain in the clinical environment; however, the aim is to reduce the ligature anchor points to a level as far as reasonably practicable, and in a manner considered to be proportionate to the risks presented in each clinical environment.

3.7 In addition, the Trust recognises that in some areas, including older people’s wards, a balance needs to be struck between reducing the risk from ligature anchor points and maintaining some fixtures and fittings as aids to daily living for the patient group. For example, handrails, grab rails, door handles and sink taps, all necessary aids to daily living for a particular group of patients, may remain in place,

3.8 All ligature anchor point audits, risk assessments and mitigation plans must be reviewed at least annually or following a serious incident involving the use of a ligature or when a change occurs to the environment, room use, services provided or as the need of an individual or groups of patients/service users dictates.

3.9 The annual ligature anchor point assessment will also incorporate an assessment of blind spots.

- Blind Spots

There are clear lines of sight to enable staff members to view patients. Measures are taken to address blind spots and ensure sightlines are not impeded, e.g., by using mirrors.

4. Control Management and Mitigation Process

4.1 All clinical staff have a responsibility to protect patients from harm. Actions to be taken in this regard must ensure:

- That risks are communicated between staff, between shifts, between different clinical disciplines (e.g., medical, nursing and others), forums (safety huddles, handovers and MDTs) and between services involved in the patients care.

- That staff have been provided with information, instruction and local training on the identification and control of ligature anchor points, ligatures and blind spots and those records of such training are maintained on staff training logs.

- That ward staff understand and are aware of the location of patient safety hazards (including those relating to LAPs, ligatures and blind spots) in their clinical areas.

- That engagement with, and observation of patients is undertaken in line with the Trust Policy in Engagement of Patients.

- That access to immediate hazards is eliminated, if possible, for instance by physically locking off the room or area concerned, if possible or removal of the ligature anchor point where possible, e.g., removal of coat hook. Patient observations may also need to be considered. If an area becomes restricted, consider if an interim Blanket Restriction needs to be recorded and inform Head of Service.

- The escalation of immediate hazards to the Ward/Team Manager and, if appropriate, the Health and Safety Risk Adviser and General Manager. These should also be recorded on an incident form.

- Staff are trained aligned to the Policy for the removal of ligatures to ensure there is an effective emergency response capability, readily available, including the availability of ligature cutters and staff competent to use them effectively.

5. Never Event

5.1 An incident where a patient has attempted or succeeded to complete suicide using a curtain rail system may be deemed as a 'Never Event' as below and must be reported and escalated using the Incident Reporting system:

Never Event	Details
Failure to install functional collapsible shower or curtain rails.	• Failure of collapsible curtain or shower rails to collapse when an inpatient attempt or completes a suicide. • Failure to install collapsible rails and an inpatient attempt or completes a suicide using non-collapsible rails.

6. Roles and responsibilities

6.1 Chief Executive

To ensure that governance arrangements are in place to effectively manage reduction in ligature risks and provide the resources necessary.

6.2 Executive Director of Nursing, Professions and Operations

The Director of Nursing is the accountable Director responsible for ensuring that an appropriate and effective system is in place for the annual Ligature Anchor Point Risk Assessment's and associated management and follow up of the outcomes including:

- Development and review of this Policy
- Ensuring Trust wide implementation and compliance with this policy
- Having oversight of the delivery of the annual ligature anchor point audits to mitigate and seek assurances
- Ensuring reporting via `Back to Good Board` (for its duration) and to the Quality Assurance Committee on the programme and management of the removal of ligature anchor points.
- Ensuring an annual assurance report is copied to the Trust Health, Safety & Fire Committee.

6.3 Clinical Directorates

All Clinical Directorate Triumvirates have responsibility for ensuring that effective ligature risk management arrangements are in place within their Directorate; this is assigned to the **Head of Service.** This must include:

- That assessments have been completed across the Directorates and that they designate specific senior managers to oversee and assure this activity
- That the outcomes of all assessments are communicated to ensure that all ligature anchor points are discussed, and funding agreed where removal/replacement is required.
- They have direct line of sight to the estates work programme which allocates programmes of work to removal of ligature anchor points; ensuring that robust communication takes place between clinical teams and estates staff to ensure minimum disruption and delays.
- That they provide an appropriate number of senior level, suitably trained and competent clinical staff to form part of the Ligature Anchor Point Audit team for the Directorate.
- That they have effective arrangements in place for planning, implementation, monitoring and review of the ligature anchor point risk assessment process.
- That they ensure that any significant unresolved ligature anchor point related risks are escalated appropriately; including being brought to the Quality Assurance Committee/ Back to Good Board (for its duration) if necessary.

6.4 Heads of Nursing

Are responsible for ensuring that:

- Control measures (mitigation) and safe systems of work (training) including clinical practice (e.g., clinical risk assessment, handovers, observations, searches, blanket restriction register etc.) are developed and implemented in accordance with this policy and related suicide prevention strategies

- Clinical teams implement mitigation measures and record risks on the team risk register, with significant concerns being escalated to the Directorate Risk Register.
- They report the ligature anchor point audit findings to the Directorate Performance and Quality Review (PQR) meetings and Clinical Quality and Safety Group on a when required basis.
- They and all their staff work to this Policy and other related policies.
- Write the Annual Ligature Anchor Point Assurance report for their Directorate in conjunction with colleagues across the services and facilities/estates

6.5 Ward/ Unit Manager

Ward/unit managers are responsible for ensuring that:

- This policy and ligature removal policy are brought to the attention of all their staff and implemented within the service area of their responsibility
- Mitigation measures and safe systems of work including clinical practice (e.g., observations, searches etc.) are developed and implemented in accordance with this policy and related suicide prevention strategies
- Ligature Anchor Point and Blind Spot audits are conducted at least annually or following a serious incident (SI) or sooner if any structural, decorative changes or improvements are made to the environment, ensuring that risk assessments are undertaken and actions taken are appropriate, recorded, and recommendations are acted upon
- A local ligature risk management plan reflecting the findings of the ligature anchor point audit and assessment, is in place and brought to the attention of all staff working on the ward/unit (including bank and agency staff)
- That all staff working on the ward/team (including bank and agency staff) are made fully aware of what a 'Potential Ligature Anchor Point' (PLAP) and Blind Spot is, and where the most significant and/or relevant risks in this regard are to be found in the ward/team
- The local ligature risk management plan (including locations of remaining PLAPs/Blind Spots) is part of the Induction process for all new staff, including students, temporary/bank staff and junior doctors who are on placements
- Maintaining appropriate records of site audits and risk assessments.

6.6 Director of Strategy

The Director of Strategy is responsible for:

- Ensuring that the agreed anti-ligature designs and installations are incorporated within development works undertaken by the Trust
- The planning and delivery of the Trust's annual Ligature Anchor Point and Blind Spot reduction programme
- Contributing to the annual Ligature Anchor Point and Blind Spot Risk Reduction assurance report and reports to the Quality Assurance Committee on the programme and management of ligature anchor point risks.

6.7 Health & Safety Risk Team

The Health & Safety Risk Manager is responsible for:

- Conducting random inspections and audit to assess the standard of anti-ligature fixtures and review assessments.

- Working in close liaison with Capital Projects & Planning and Estates & Facilities department in identifying suitable and specific anti-ligature products and realistic solutions to ligature issues across the Trust
- Assisting with the risk assessment process

6.8 Ligature Anchor Point & Blind Spot Assessment Audit Team

The assessment team should include 3 of the following professionals:

- Estates Team
- Health and Safety Representation
- The Patient Safety Team
- Patient facing staff – Ward Manager, Modern Matrons and their Deputies.
- Heads of Nursing and their Deputies
- Independent Assessor (Third pair of eyes, for example from a neighbouring Trust or assessor "bank" member)

The ward managers, modern matrons or their deputies must attend LAP audits for each of their clinical areas. The Health Service Executive states *"A number of staff members must complete the audit, of which at least one should be part of the multidisciplinary team from that clinical area"*

This will be closely followed by Estates as suggested by the Health Service Executive, and the third membership can alternate between the remaining options to prevent over familiarisation with the wards. SHSC should propose the creation of an assessment "bank" of people who are a third pair of eyes available to do an assessment when they are due.

7. Training

7.1 All clinical staff that complete the assessment tools will be provided with work-based development and mentorship in the assessment process and completion of the tools.

8. Ligature Anchor Point Audit and Risk Assessment Process

The Trust requirement is for all in-patient wards, residential specialist care homes/units and outpatient/community settings where patients may attend to have a valid ligature anchor point audit, risk assessment and risk management plan in place. These audits, assessments and risk management plan must be undertaken or reviewed:

- Annually
- In response to a serious incident involving an attempted suicide or possible suicide in the patient area
- Following any significant refurbishment and building works in the patient area.

8.1 Clinical Environment Removal Group (CERG).

This group is chaired bi-monthly by the Clinical Risk and Patient Safety Advisor. CERG will:

- Oversee that relevant alerts are noted, analysed, and acted upon.
- Hold a database of all Ligature Anchor Point/Blind Spot Audit (LAP-BS) Audits in a central place for oversight.
- Organise the LAP-BS Audit through use of appropriately trained members.
- Be able to provide assurance of the sign-off process of the LAP-BS and appropriate monitoring of recommendations.

CERG will receive the LAP-BS audit via modern matrons/service managers for review and final sign-off on behalf of SHSC. Each audit will be reviewed at regular periods to ensure actions are being completed and updated on the LAP-BS. Clinical areas will be sent the most up to date LAP-BS from CERG and will be required to represent their service when appropriate.

8.1 In-Patient Wards/Residential Units

All audits of ward/residential units will be undertaken in accordance with the Guidance on the Ligature Audit Assessment Procedure – Inpatient Areas.

8.1.1 All rooms and areas within the security perimeter of the ward must be considered in the audit, but of particular importance, is anywhere that patients could spend time alone and/or unaccompanied by staff, e.g., bedrooms, shower rooms, toilets/ bathrooms, garden.

8.1.2 Once the ligature anchor point audit risk rating has been determined the existing controls should be identified, recorded and an assessment made of the residual risk (i.e., are the compensating actions sufficient to reduce the risk of the ligature anchor point to an acceptable level).

8.1.3 It is important to note that the ligature anchor point, and blind spot audit risk rating is a measure of the priority for mitigation. LAPs with low ratings should not be considered as safe, they can still be a risk to patients (e.g., low height LAPs in bedrooms remain a significant risk that may require further mitigation measures).

8.1.4 The Guidance on the Ligature Anchor Point & Blind Spot Audit Assessment Procedure – Inpatient Areas will assist in the identification, assessment and appropriate control of ligature risks.

8.1.5 It is essential that where a residual risk above an acceptable level is identified that control strategies appropriate for the level of risk (the risk management plan see section 9.1) and any additional actions (such as removal or replacement – see section 9.2-9.4) are instigated, monitored reviewed to ensure they mitigate the risk and remain effective.

8.2 Community Premises (including Out-patient/OT Facilities)

All audits of community premises where patients are seen (including outpatients and OT facilities) will be undertaken in accordance with the Guidance on the Ligature Audit Assessment Procedure: non-ward settings.

8.2.1 Community ligature anchor point and blind spot audits and assessments will specifically focus on waiting areas, patient toilets and any areas where access is not restricted.

8.2.2 The Guidance on the Ligature Anchor Point & Blind Spot Audit Assessment Procedure non-ward settings will assist in the identification, assessment and appropriate control of ligature risks.

8.2.3 It is essential that where a residual risk above an acceptable level is identified that control strategies appropriate for the level of risk (the risk management plan see section 9.1) and any additional actions (such as removal or replacement – see section 9.2 - 9.4) are instigated, monitored reviewed to ensure they mitigate the risk and remain effective.

9. Approach to Ligature Risk Management

9.1 Risk Management Plan

Every ward and community setting must have an up-to-date ligature risk management plan that reflect the findings of the ligature audit/assessment. The plans will be informed by the findings of the ligature anchor point audits and assessments.

9.1.1 Wards ligature risk management plans

The plans will be specific to each ward but would typically include:

- Details of all doors that must be kept locked when not in use
- Rooms/areas to be used under supervision
- Staff only rooms/areas
- Protocol for garden access and supervision
- Environment checks
- Location of ligature cutters
- Details of all high-risk ligature anchor points remaining on the ward (this should include a general reminder of risk from fire detectors and tops of doors)

9.1.2 Community settings ligature risk management plans

The plans will be specific to each community site but would typically include:

- Details of all doors that must be kept locked when not in use
- Rooms/areas to be used under supervision
- Additional measures in place for, isolated areas etc.
- Staff only rooms/areas
- Location of ligature cutters
- Details of the local procedures for:
- a patient presenting acutely unwell
- patients use of toilets not in close proximity to the reception area,
- use and accompanying patients to and from interview/clinic rooms
- isolated areas

9.1.2.1 The arrangements for patient's use of toilets not in close proximity to the reception area may include escorting the patient to the toilet and monitor their return to the waiting area.

9.1.2.2 The procedure for the use of interview/therapy/clinic rooms should clearly indicate patients should not be left unsupervised at any point during their appointment and if an appointment is interrupted for whatever reason, the patient should be escorted back to the waiting area.

9.1.2.3 In the event of clinical teams being unclear about a ligature anchor point or blind spot or future management responses, the Ward/Team Manager must escalate this to the relevant Operational Directorates Lead Nurse and/or the Health & Safety Adviser.

9.2 Action planning

Following a Ligature Anchor Point & Blind Spot Assessment an action plan must be created for all ligature anchor points and blind spots identified as an unacceptable ligature risk.

9.2.1 It is important to consider elimination of the ligature anchor point as the best risk management solution.

9.2.3 Where elimination is not possible replacement with anti-ligature fittings should be considered.

9.2.4 Where elimination or replacement is not possible, local action must be taken within the team, for example (not exclusive list):

- restricting access
- ensuring the room is always supervised in use
- increasing observations (particularly for high risk patients)
- changes to operational procedure
- ensuring all staff are aware of the increased risk

9.2.5 In addition, where mitigation works is technically impossible or may lead to a poor therapeutic environment this should be clearly recorded on the audit/assessment sheet together with details of the additional local mitigation necessary to reduce the risk.

9.2.6 It is important that when mitigation works are identified as necessary, until they are completed, appropriate interim local actions must be taken to reduce the on-going risk to the lowest level possible. This would generally be similar to above but where the risk is significant the particular room/area may need to be closed off in the interim if the risk remains unacceptable.

9.3 Escalating Action

The Ward/Team Manager and Clinical Lead should review the results of the ligature anchor point audit and assessment and specifically the actions identified as necessary for escalation. Significant uncontrolled risk should be immediately dealt with (see below).

9.3.1 Consideration should be given to whether any risks need to be entered onto the Directorates risk register in the interim until they are addressed.

9.3.2 The Head of Nursing must then submit the details of the escalated risks and recommended mitigation works to the Head of Service.

9.3.3 The Head of Service must produce an annual Ligature Anchor Point and Blind Spot Risk Reduction programme from all the escalated risks highlighted in the reports and arrange for its appropriate funding, addressing the highest risks first.

9.3.4 Currently there is a significant ligature anchor point removal programme underway for inpatient services. This aims to address most current ligature anchor points during 2021/22.

9.3.5 For community services some mitigation works can be undertaken by estates, it is likely that many ligature anchor points may require specialist work/fittings or significant expenditure, that will require funding outside of the Directorates budget. These will normally be addressed via the Trust's annual ligature reduction programme, but as necessary the Head of Service will have to apply for additional capital programme funding using the audit and assessment findings to support the Business Case.

9.4 Annual Ligature Reduction Programme

The annual ligature reduction programme will address the Head of Service's escalated risks identified from the audit/assessment, addressing the highest risk first.

9.4.1 The Director of Facilities in liaison with the Heads of Service will develop an annual ligature reduction programme from the escalated risks and submit for funding via the Capital Programme Group.

9.5 Capital Projects & Planning Department

Capital Planning Projects will ensure that all works are carried out within an agreed timeframe subject to final approved audits and approved funding. Where there are, issues impacting upon the completion of works this will be escalated to the Director of Facilities and the Director of Nursing. Where timescales allow, works will be grouped together in works packages by hospital site and tendered on the open market in line with Trust Financial Instructions. Where works are required to be completed without time to complete a full tender, the Director of Nursing and/or the Director of Finance will be required to sign a tender waiver.

9.5.1 Where works are required to be completed within a live ward environment, wards will be expected to provide a dedicated member of staff to act as a chaperone for the duration of the works.

9.6 Estates & Facilities Department

Estates & Facilities Department will have responsibility for completing any works which have been submitted via a Planet FM request. Where works cannot be completed, they should identify this to the Head of Capital Development and the Clinical Quality and Safety Group for escalation and addition to the annual ligature reduction programme.

9.7 Actions for Significant Uncontrolled Risks

The ward/unit manager must immediately escalate any identified significant uncontrolled risks to the Head of Nursing (or in their absence their Head of Service).

9.7.1 The Head of Nursing should report the uncontrolled risks to the Head of Service and Director of Quality/Director of Operations who must as a priority arrange for appropriate funding for the remedial measures to be address as soon as possible.

9.7.2 In the interim until such point that funding can be identified to eliminate or reduce them, the Head of Nursing must ensure that temporary measures are urgently put in place and maintained to manage these risks. This may require for example, additional staff resources to be provided for the enhanced therapeutic engagement and observation of the patient group or the temporary locking off, of the affected area. This approach will be agreed and signed off by the Triumvirate and shared with the Director of Quality/Director of Operations.

9.8 Patient Possessions

On wards patient possessions could potentially be used as ligatures or a means of asphyxiation. More information is given in the Policy for the removal of Ligatures.

10. Monitoring, Audit and Review

Implementation of this policy will be managed via the following governance routes :

- **Monthly** reporting on progress against the completion of Ligature Anchor Point Assessments to take place through Clinical Quality and Safety Group by Heads of Nursing and Patient Safety Specialist.

- **Annual report** on the completion of the Assessments through the Clinical Quality and Safety Group copied to Health and Safety Committee and Therapeutic Environments Group (led by Heads of Nursing)
- **The report will include:**

  - Review of all action plans to take place within each directorate with confirmation of this review being documented in the annual report.
  - Outstanding ligature anchor points which are awaiting removal or replacement must be highlighted in the report with a narrative to identify timescales for the work to be completed or any funding gaps.
  - An overview of adverse incident data will be included within the report to identify any potential areas of risk

10.2 **Compliance Completion Rates**

Compliance completion rates and action plans should be monitored through the Clinical Quality and Safety Group.

10.3 **Monitoring Compliance**

What will be monitored i.e., measurable policy objective	Method of Monitoring	Monitoring frequency	Position responsible for performing the monitoring/ performing co-ordinating	Group(s)/committee (s) monitoring is reported to, inc. responsibility for action plans and changes in practice as a result
Completion of risk assessments and audits	Monitor completed assessments	Monthly	Clinical Directorates H&S Risk Manager & H&S Advisers	Clinical Quality and Safety Group Health and Safety Committee Quality Committee
Completion of action plans from assessments	Monitor and record returns from assessments	Monthly	Heads of Service H&S Advisers	Directorate performance and quality reviews

Audit and review of risk assessments on an annual basis	Monitor completed assessment	Annually	Heads of Nursing Patient safety specialist H&S Advisers	Clinical Quality and Safety Group Quality Assurance Committee Back to Good board
Monitoring of ligature reduction programme	Sign off reports	Quarterly	Director of Facilities / Director of Operations	Back to Good Board
Monitoring of adverse incident data	Monitor via Ulysses	On-going	Heads of Nursing, Patient safety specialist	Clinical Quality and Safety Group IPQR
Audits of suicides in in-patient facilities	Monitor via NCISH	On-going	Patient safety specialist, Director of Quality	Clinical Quality and Safety Group

10.4 **Review**

This policy was initially reviewed within 6 months of ratification. Following the initial 6 month review it will now move to a 3 yearly review cycle, or earlier if required, due to concerns identified through monitoring the policy, changes in national guidance, legislation, significant concerns raised via enforcement action or significant incidents. Therefore, the review will be October 2025.

10.5 Clinical Quality and Safety Group

The main role of the group is to receive assurance via the Heads of Nursing and Patient Safety Specialist that the plan of programmed audits and completed action plans is up to date and that risks are being recorded and acted upon.

This group will also ensure that the policy remains fit for purpose and is adhered to through the receipt of the annual assurance report from the Heads of Nursing.

The group will ensure receive assurance on training and work aligned to this policy such as the Policy for ligature removal, risk assessment and clinical management and observations and engagement policy and any concerns regarding ligature removal.

10.6 Back to Good Board (for its duration)

The main role of this Board is to receive assurance on the completion of the works to remove or replace with reduced risk fittings, the ligature anchor points identified

across inpatient environments across the Trust as identified within the annual assessment process.

10.7 Concerns from Clinical Quality and Safety Group or Back to Good Board will be escalated to Quality Assurance Committee.

10.8 For assurance purposes the monitoring and review of the status of the ligature risk audit and reduction programme across the Trust report to the following:

Forum	Frequency
Quality Assurance Committee	Annually
Clinical Quality and Safety Group	Bi-Monthly
Health, Safety & Fire Committee	Annually
Directorates IPQR	Quarterly

11. Additional Support and Guidance

11.1 If after reading this document, you feel that you still required further guidance you should contact the Clinical Risk and Patient Safety Advisor.

12. Dissemination, Storage and Archiving (Control)

Links to an electronic copy of the policy shall be circulated to all staff via the Trust Communications. Any hard copies of the previous version should be replaced.

An electronic copy of the policy shall be accessible via the Trust Intranet and but not the public facing Internet.

An archived copy of the previous policy and the new updated policy shall be stored with the Corporate Governance team for reference.

13. Implementation Plan

Action/Task	Responsible Person	Timescale
New policy to be uploaded onto the Intranet and Trust website.	Head of Communications	Within 5 working days of ratification
A communication will be issued to all staff via the Trust Communication immediately following publication.	Head of Communication	Within 5 working days of ratification
A communication will be sent to Education, Training and Development to review training provision.	Head of Clinical Governance	Within 5 working days of ratification

Ensure the policy and arrangements has been implemented within the Clinical /Service Directorates	Head of Service	Within 5 working days of ratification

14. Associated Documents

- MD 023 Incident Management Policy and Procedure (including Serious Incidents)
- Risk Management Strategy, Policy and Procedure
- OPS 013 Personal Search Policy
- MD 010 Duty of Candour and Being Open Policy and Procedure
- NP 016 Safeguarding Adults & PREVENT Policy
- NPCS 007 Resuscitation Policy

15. References

- Health & Safety at Work etc. Act 1974
- Management of Health and Safety at Work Regulations 1999
- NRLS Preventing Suicide – A toolkit for Mental Health Services 2009
- DH Estates and Facilities (2010) Alert: EFA/2010/007 Window blinds with looped cords or chains. All types.
- DH Estates and Facilities (2007) Alert: DH (2007)08 Cubical curtain track rails (anti ligature)
- DH Estates and Facilities (2010) Alert: EFA/2010/011 Self-harm associated with wardrobes
- South London and Maudsley NHS Foundation Trust Ligature Anchor Point Reduction Policy
- National Patient Safety Agency (2014) Preventing Suicide A Toolkit for Mental Health Services
- CQC (2017) Out of sight – who cares?: Restraint, segregation and seclusion review

Appendix A – Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
1.2	Draft policy creation	May 2015 – November 2016	Previous guidance in operation updated to policy status.
1.3	Review of existing policy	November 2017	Previous guidance in operation updated to policy status.
1.4	Rewrite of existing policy	December 2020	Full rewrite of policy and assessment tools
1.5	Rewrite of draft policy	August 2021	Separation of ligature removal requirements from ligature anchor point assessment policy. Update responsibilities and tidy policy and governance routes to align with Back to Good programme of work.
1.7	Policy approved	December 2021/January 2022	Policy approved at PGG and ratified at QAC
2.0	The new additional CERG Process	September/October 2022	CERG proposal reviewed at CQSG and QAC for approval.
2.0	Review of the policy and submission to PGG.	October 2022	Implementation of process for CERG into the policy.

Appendix B – Dissemination Record

Version	Date on website (intranet and internet)	Date of "all SHSC staff" email	Any other promotion/ dissemination (include dates)
1.7	January 2022	January 2022	
2	November 2022	November 2022	N/A

Appendix C – Stage One Equality Impact Assessment Form

Equality Impact Assessment Process for Policies Developed Under the Policy on Policies

Stage 1 – Complete draft policy

Stage 2 – **Relevance** - Is the policy potentially relevant to equality i.e., will this policy potentially impact on staff, patients or the public? If **NO** – No further action required – please sign and date the following statement. If **YES –** proceed to stage 3

This policy does not impact on staff, patients or the public (insert name and date) GRACE KINSEY-OXSPRING, October 2022

Stage 3 – **Policy Screening** - Public authorities are legally required to have „due regard" to eliminating discrimination, advancing equal opportunity and fostering good relations , in relation to people who share certain „protected characteristics" and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance on equality impact assessment for examples and detailed advice. This is available by logging-on to the Intranet first and then following this link https://nww.xct.nhs.uk/widget.php?wdg=wdg_general_info&page=464

	Does any aspect of this policy actually or potentially discriminate against	**Can equality of opportunity for this group be improved through this policy or changes to this policy?**	**Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?**
AGE	No	Yes. This policy has the potential for positive impact for ages by helping the Trust fulfil its legal obligation under by adhering to the guidance and control of all potential ligature anchor point risks and also the Management of Health and Safety At Work Regulations 1999. Older people may have particular needs in relation to having standard equipment and fittings in their environment. The Trust must remain mindful of how this policy is meeting these needs for mobility etc	
DISABILITY	**No**	People with disabilities (either physical or mental) may have particular needs in relation to ligature management. The Trust must remain mindful of how this policy is meeting these needs.	
GENDER REASSIGNMENT	**No**	The policy has the potential positive impact for people of all gender identities by helping the Trust fulfil its legal obligation under the Management of Health and Safety at Work Regulations 1999.	
PREGNANCY AND MATERNITY	**No**	This policy has a potentially positive impact for pregnant people by helping the Trust fulfil its legal obligation under the Management of Health and Safety at Work Regulations 1999.	

ff

	Does any aspect of this policy actually or potentially discriminate against	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
RACE	**No**	This policy has a potentially positive impact for people of all ethnicities by helping the Trust fulfil its legal obligation under the Management of Health and Safety at Work Regulations 1999.	
RELIGION OR BELIEF	**No**	This policy has a potentially positive impact for people of all religions and beliefs by helping the Trust fulfil its legal obligation under the Management of Health and Safety at Work Regulations 1999.	
SEX	**No**	This policy has a potentially positive impact for people of all sexes by helping the Trust fulfil its legal obligation under the Management of Health and Safety at Work Regulations 1999.	
SEXUAL ORIENTATION	**No**	This policy has a potentially positive impact for people of all sexes by helping the Trust fulfil its legal obligation under the Management of Health and Safety at Work Regulations 1999.	

Stage 4 – **Policy Revision** - Make amendments to the policy or identify any remedial action required (action should be noted in the policy implementation plan section)

~~Please delete as appropriate: Policy Amended / Action Identified / no changes made.~~

Impact Assessment Completed by (insert name and date)

Grace Kinsey-Oxspring October 2022

Appendix D - Human Rights Act Assessment Form and Flowchart

You need to be confident that no aspect of this policy breaches a person's Human Rights. You can assume that if a policy is directly based on a law or national policy it will not therefore breach Human Rights.

If the policy or any procedures in the policy, are based on a local decision which impact on individuals, then you will need to make sure their human rights are not breached. To do this, you will need to refer to the more detailed guidance that is available on the SHSC web site http://www.justice.gov.uk/downloads/human-rights/act-studyguide.pdf
(Relevant sections numbers are referenced in grey boxes on diagram) and work through the flow chart on the next page.

1. Is your policy based on and in line with the current law (including case law) or policy?

✓ **Yes. No further action needed.**

☐ **No. Work through the flow diagram over the page and then answer questions 2 and 3 below.**

2. On completion of flow diagram – is further action needed?

✓ **No, no further action needed.**

☐ **Yes, go to question 3**

3. Complete the table below to provide details of the actions required

Action required	By what date	Responsible Person

Human Rights Assessment Flow Chart

Complete text answers in boxes 1.1 – 1.3 and highlight your path through the flowchart by filling the YES/NO boxes red (do this by clicking on the YES/NO text boxes and then from the Format menu on the toolbar, choose „Format Text Box" and choose red from the Fill colour option).

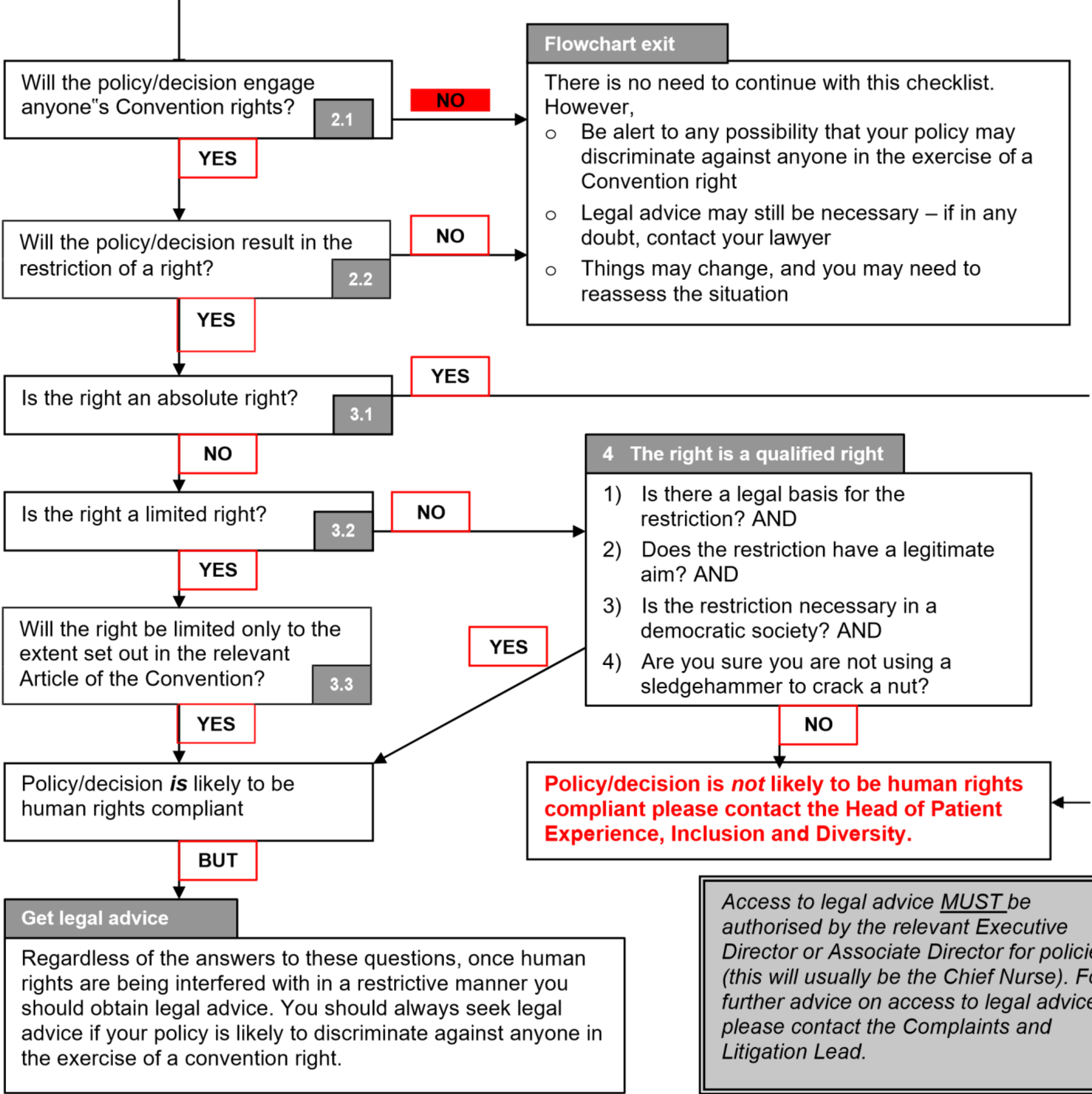
Once the flowchart is completed, return to the previous page to complete the Human Rights Act Assessment Form.

1

1.1 policy/decision title? Ligature Risk Reduction Policy and Procedure

1.2
What is the objective
of the policy/decision? To guide staff in reducing ligatures

1


1.3 Who will be affected by the policy/decision? Service users……………………………………..
1
Will the policy/decision engage anyone"s Convention rights?
2.1
NO
Flowchart exit
There is no need to continue with this checklist. However,
Be alert to any possibility that your policy may discriminate against anyone in the exercise of a Convention right
Legal advice may still be necessary – if in any doubt, contact your lawyer
Things may change, and you may need to reassess the situation
YES
Will the policy/decision result in the restriction of a right?
2.2
NO
YES
Is the right an absolute right?
3.1
YES
NO
4 The right is a qualified right
1) Is there a legal basis for the restriction? AND
2) Does the restriction have a legitimate aim? AND
3) Is the restriction necessary in a democratic society? AND
4) Are you sure you are not using a sledgehammer to crack a nut?
Is the right a limited right?
3.2
NO
YES
Will the right be limited only to the extent set out in the relevant Article of the Convention?
3.3
YES
YES
NO
Policy/decision is likely to be human rights compliant
Policy/decision is not likely to be human rights compliant please contact the Head of Patient Experience, Inclusion and Diversity.
BUT
Get legal advice
Regardless of the answers to these questions, once human rights are being interfered with in a restrictive manner you should obtain legal advice. You should always seek legal advice if your policy is likely to discriminate against anyone in the exercise of a convention right.
Access to legal advice MUST be authorised by the relevant Executive Director or Associate Director for policies (this will usually be the Chief Nurse). For further advice on access to legal advice, please contact the Complaints and Litigation Lead.

Appendix E

Questions from CQC Audit for Sign-off

a. Reflect all the aspects counted as 'high risk' above?
b. Green or amber ratings are not given to any areas counted as 'high
c. Low priority 'score' not given any of the areas counted as 'high risk' above
d. Specific heights above the floor to designate a ligature anchor point are not 'low risk'
e. Consider environmental risks from suffocation, self-poisoning, cutting/stabbing, etc. as well as ligature anchor points/ligatures
f. Include arrangements for purchasing, fitting, and maintaining ligature reducing devices and use of digital solutions to improve safety
g. Protect from public and patient view, material that could be used to identify detail of means of self-harm

Appendix F

Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Tick to confirm
	Engagement	
1.	Is the Executive Lead sighted on the development/review of the policy?	√
2.	Is the local Policy Champion member sighted on the development/review of the policy?	√
	Development and Consultation	
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	N/A
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	√
5.	Has the policy been discussed and agreed by the local governance groups?	√
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	√
	Template Compliance	
7.	Has the version control/storage section been updated?	√
8.	Is the policy title clear and unambiguous?	√
9.	Is the policy in Arial font 12?	√
10.	Have page numbers been inserted?	√
11.	Has the policy been quality checked for spelling errors, links, accuracy?	√
	Policy Content	
12.	Is the purpose of the policy clear?	√
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate)	√
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?	√
15.	Where appropriate, does the policy contain a list of definitions of terms used?	√
16.	Does the policy include any references to other associated policies and key documents?	√
17.	Has the EIA Form been completed (Appendix 1)?	√
	Dissemination, Implementation, Review and Audit Compliance	
18.	Does the dissemination plan identify how the policy will be implemented?	√
19.	Does the dissemination plan include the necessary training/support to ensure compliance?	√
20.	Is there a plan to review audit compliance with the document?	√
21.	Is the review date identified, and is it appropriate and justifiable?	√