		Agenda Item No: 8
SUMMARY REPORT	**FINANCE & PERFORMANCE COMMITTEE**	**19th October 2023**

Report Title:	Analysis of Ligature Risk Program's Impact					
Executive/ Non-Executive Lead:	Alex Green, Chief Operations Officer					
Report Author(s):	Nicola Jones, Director of Risk and Compliance					
Report discussed previously at:	Ligature Risk Reduction Group (LRRG)					
Level of Assurance:	**Level 1**	√	**Level 2**		**Level 3**	

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report	CRR81 -	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	√
	SR2 People (workforce)	
	SR3 Finance and Resources Infrastructure	√
	SR4 Demand/ Capacity	
	SR5 Statutory Public Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	√
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	~~Yes/~~ No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	~~Yes/~~ No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

Project reports only:	
If this report is project related please state whether this has been approved through the Transformation Steering Group	Yes/No

Purpose of the Report		
This report provides the Finance & Performance Committee with: • Analysis of ligature incidents reported by EPUT inpatient MH services.	**Approval**	
	Discussion	√
	Information	

Recommendations/Action Required
The Finance & Performance Committee is asked to: 1 Note the contents of the report 2 Request any further information or action

Summary of Key Issues
➢ Incidents included from April 2020 to March 2023 reported by Essex Partnership University NHS Foundation Trust (EPUT) staff. ➢ Consistent reporting levels with a period of reduction April 22 – Feb 23. ➢ Adult rates remain on average slightly above the national benchmark of 42 per 10,000 occupied bed days. ➢ Comparison of figures of secure and unsecured incidents continues to indicate there are significantly more reported ligature related incidents that do not make use of a fixed anchor point, with unsecured incidents accounting for over 97% of reported incidents across the period. ➢ Longview Ward have seen a significant reduction in the numbers of unsecured ligatures during 2022/23, which on review, follows a similar pattern for other methods of self-harming behaviour. ➢ Over the three year period, 85.9% of incidents have had a reported outcome of no harm. ➢ Items of bedding have consistently remained the highest reported ligature for secured ligatures and bedroom doors remain the most used anchor point. ➢ A high proportion of patients involved in using ligatures were female, accounting for 85.5% of the total reported during 2022/23. ➢ Increased awareness of the risks involved and the ongoing work in improving the ward environments to mitigate the risk of patients securing a ligature.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	√
SO2: We will enable each other to be the best that we can	√
SO3: We will work together with our partners to make our services better	
SO4: We will help our communities to thrive	

Which of the Trust Values are Being Delivered	
1: We care	√
2: We learn	√
3: We empower	√

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			
Data quality issues			
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			
Impact on patient safety/quality			
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**~~YES~~/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
PICU	Psychiatric Intensive Care Unit	DBT	Dialectical Behaviour Therapy
DTA	Door top alarm		
ALoS	average length of stay		

Supporting Reports/ Appendices /or further reading

Ligature Incident Analysis Report

Lead

[I/S]

Alex Green
Executive Chief Operating Officer

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Ligature Incident Analysis

Agenda Item 8
Finance & Performance Committee
19th October 2023

1.0 Purpose of Report

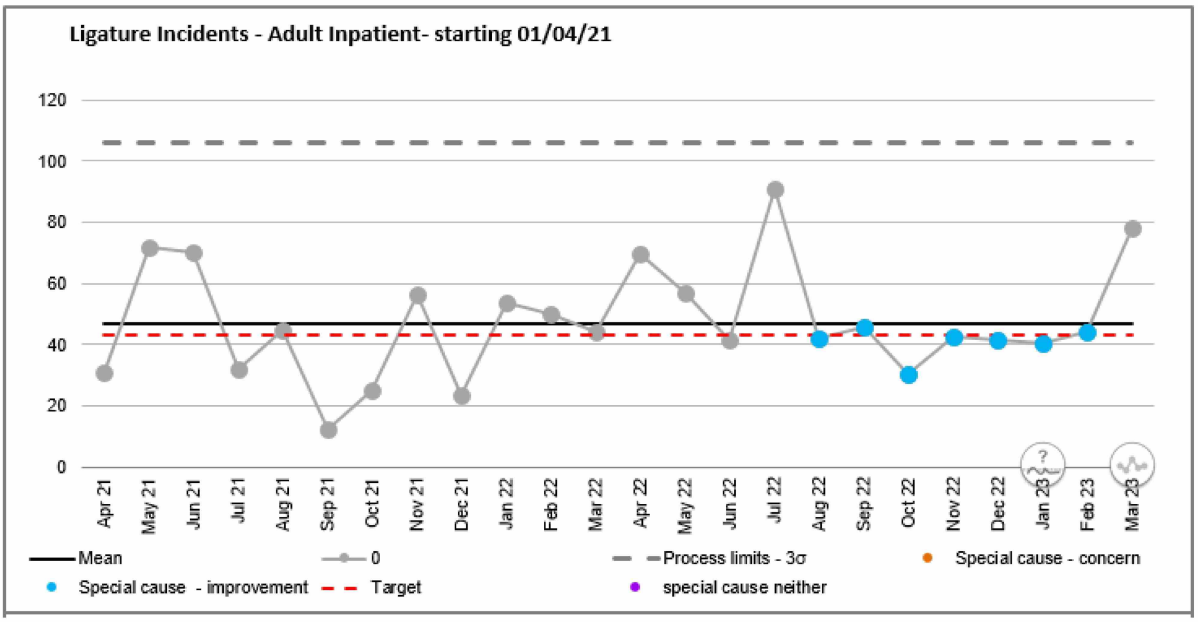
The purpose of this report is to provide ligature incident analysis from incidents reported by EPUT inpatient MH services. The report looks at a range of analysis including by ward, ligature type, and location of incident, time, day, patient demographics and where recurring incidents are attributed to the same patient.

The report details incidents from April 2020 to March 2023 reported by Essex Partnership University NHS Foundation Trust (EPUT) staff. Please note, the main body of this report includes data extracted from the Datix system, specifically the category 'Self-Harm, and sub-category 'Ligature'. However it was noted several incidents had been reported using the category 'Death', which does not record the same level of detail relating to ligatures. These incidents have been included under Section 15 of this report for information purposes.

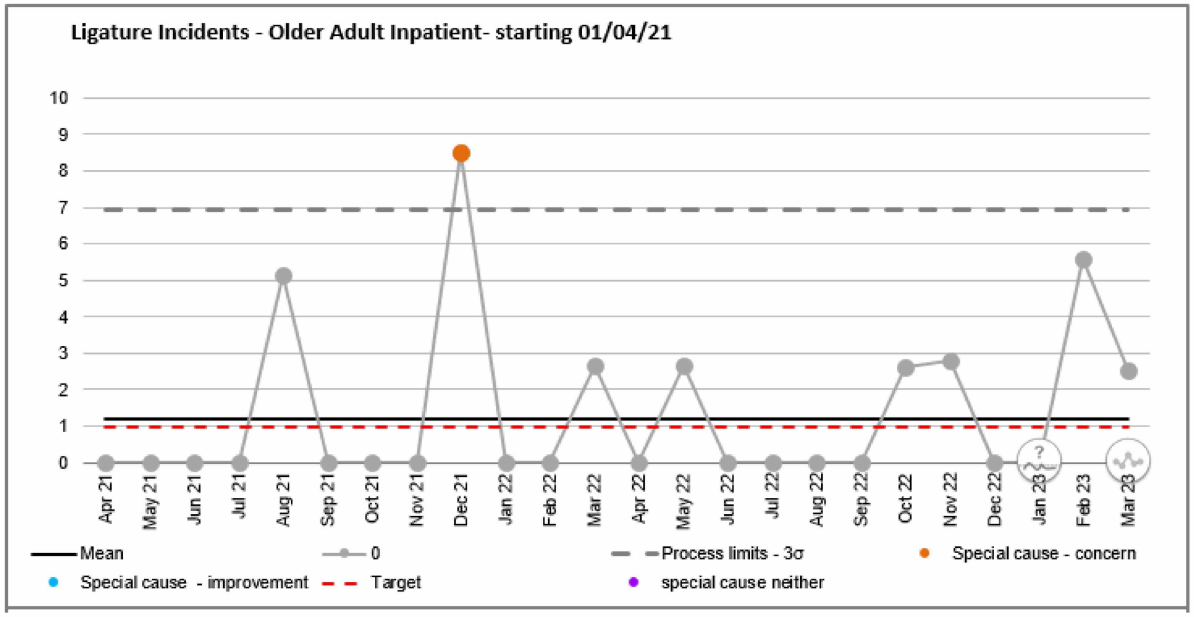
2.0 Incident Trend

Statistical process control (SPC) analysis has been undertaken of ligature incidents March 21 – March 23 to asses if any statistically significant trends can be noted.

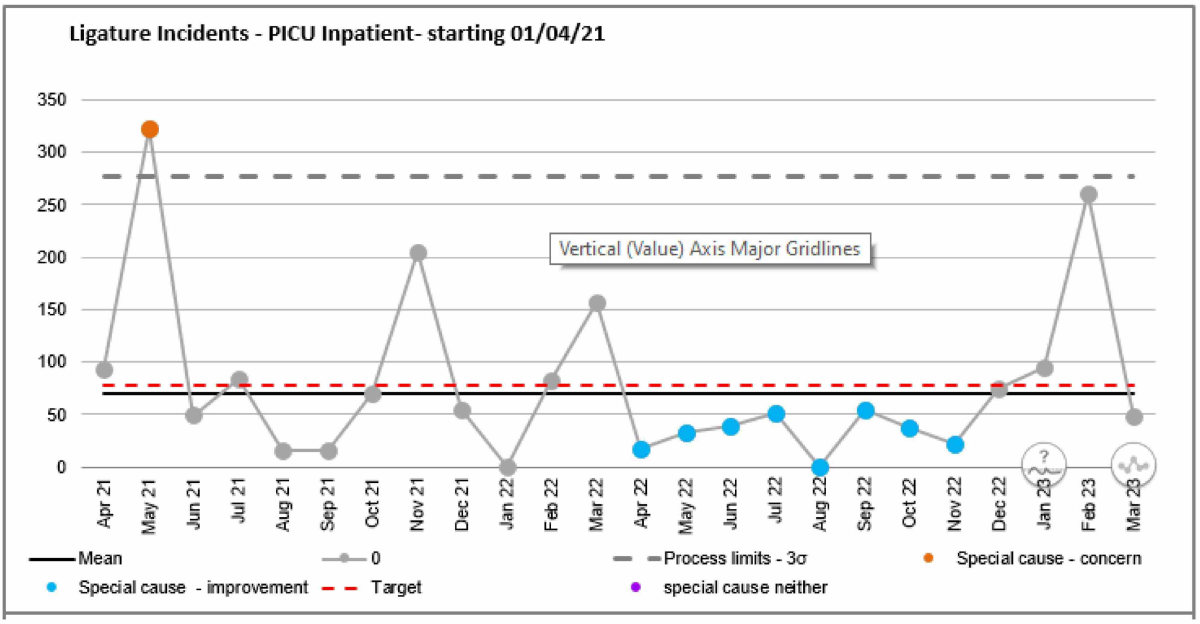
For Adults inpatients we can see a consistent reporting levels with a period of reduction April 22 – Feb 23. Adult rates remain on average slightly above the national benchmark of 42 per 10,000 occupied bed days. The higher reporting rate noted during July 2022 was predominantly due to an increase in the number of reported incidents expected on the ward. 19 incidents were recorded on Galleywood Ward during July 2022, 11 of which involved one patient.



For Older Adults numbers of ligatures are too low for any statistically significant change. Older Adult rates remain on average in line with national benchmark of 1 per 10,000 occupied bed days. The peak noted during December 2021 was due to Henneage Ward reporting two incidents and Beech Ward reporting one. The low number of incidents reported by this client group, are reflected in the chart below and this peak is due to these three incidents, compared to the other months in which zero incidents are typically recorded.



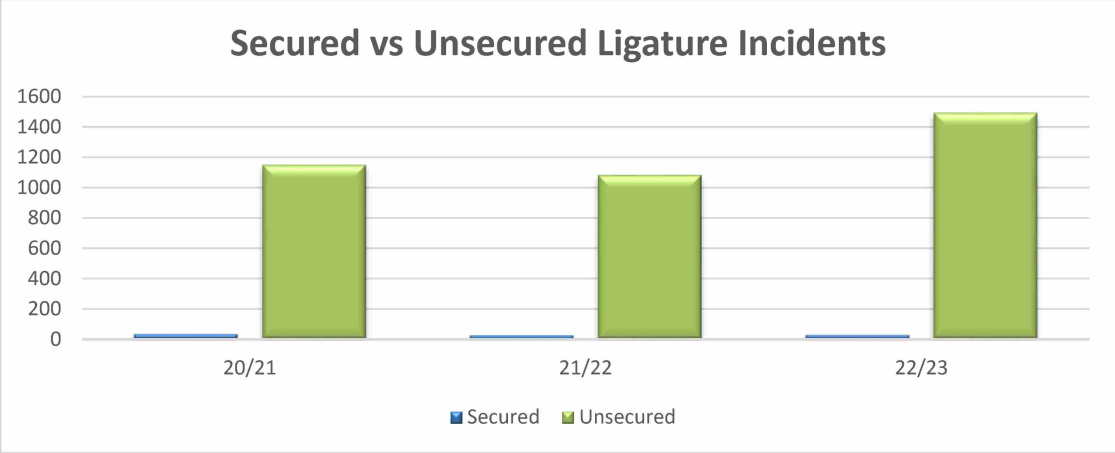
The PICU inpatient wards remain within process control limits, excluding one peak in May 2021 where 20 incidents were reported on Christopher Unit all involving the same patient.



3.0 Secured vs Unsecured Ligature

Comparison of figures of secure and unsecured incidents continues to indicate there are significantly more reported ligature related incidents that do not make use of a fixed anchor point, with unsecured incidents accounting for over 97% of reported incidents across the period. It remains vital to consider and manage ligature risks in the wider context, taking into account patient risk assessment and care planning processes, patient observation and engagement procedures and staff skill and competency mix, as well as environmental assessments.

Work to reduce physical and relational harms such as Door Top Alarms, improved search and security measures along with other environmental improvements has reduced opportunity for other forms of deliberate self-harm. This may account for the trend in increase in unsecured ligature incidents.



Clinical opinion commonly associate the majority of unsecured ligature self-harm as an expression of distress, commonly present with those with histories of trauma and abuse, rather than a direct suicide attempt. This is often care seeking behaviour and something clinical operational staff can respond to where it is identified. It is important that staff have the skills and training to identify this early, engage effectively and that services provide programmes to help address the underlying issue. The Trust's trauma informed care strategy will be important in helping to address this going forward

4.0 Incidents by Ward

The number of incidents reported involving a secured ligature has remained relatively stable over the three year period. This can be attributed to the ligature reduction work carried out by the Trust, both in raising awareness of the issue and improving/updating the ward environments to mitigate the risk.

However, the numbers of incidents involving unsecured ligatures has shown a significant increase during 2022/23, compared to the two previous years. Whilst Longview Ward have shown a reduction in unsecured ligatures, the other two CAMHS units (Larkwood Ward and Poplar Ward) have seen reported incidents increase.

The three CAMHS inpatient units account for 55.2% of the total number of reported ligature incidents and 56.0% of the number of secured ligatures.

The following table details the total number of incidents reported by individual wards by financial year:

It was noted Longview Ward have seen a significant reduction in the numbers of unsecured ligatures during 2022/23, which on review, follows a similar pattern for other methods of self-harming

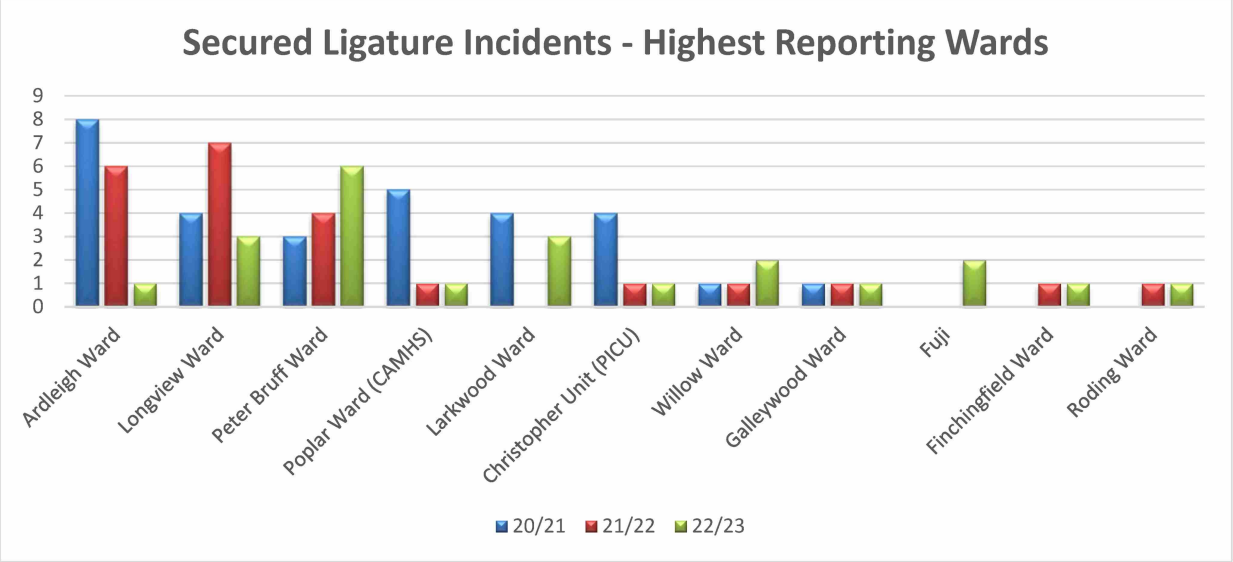
behaviour. This reduction was due to the patient numbers on the ward being reduced during this period and long periods of leave prior to discharge.

Diversely, Larkwood Ward have seen an increase in the number of unsecured ligatures during 2022/23. Other methods of self-harm decreased during 2022/23, e.g. Ingestion (2020/21 = 20; 2021/22 = 64; 2022/23 = 7). Whilst the numbers of young people on the ward were lower, the patients were acutely unwell and mostly waiting for long term, low secure placements of a higher security level. This resulted in an increased level of self-harming behaviours by ligature being exhibited.

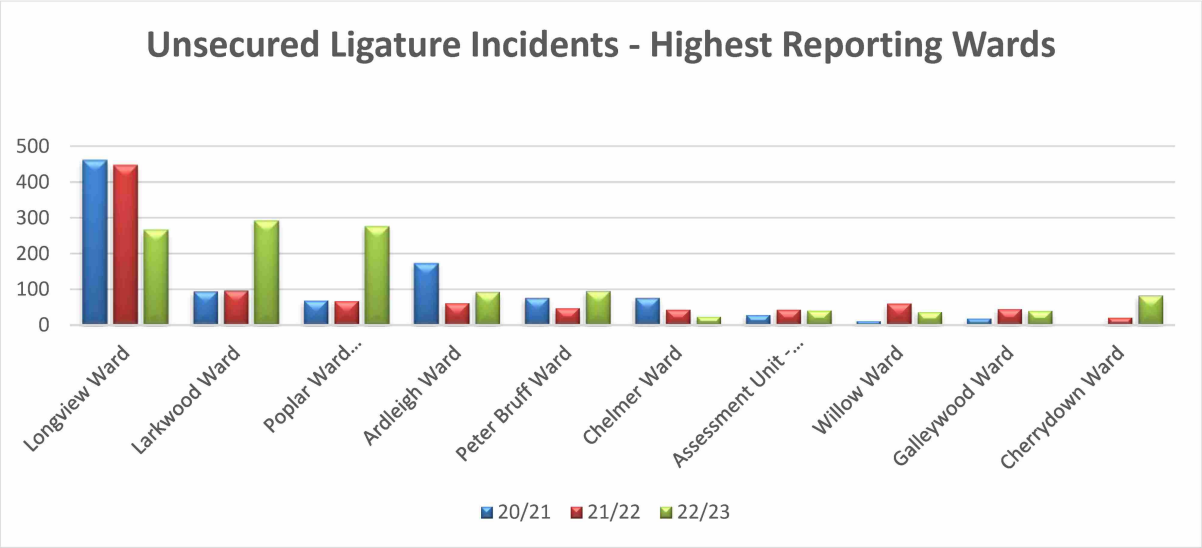
Poplar Ward also saw the levels of unsecured ligature incidents increase during 2022/23. The Matron for the ward has advised this increase was due to a specific group of young people where ligature was a more prevalent risk issue.

Ligature Incidents	Secured			Secured Total	Unsecured			Unsecured Total	Total
	20/21	21/22	22/23		20/21	21/22	22/23		
	34	26	28	88	1150	1084	1494	3728	3816
Longview Ward	4	7	3	14	462	448	267	1177	1191
Larkwood Ward	4	-	3	7	96	98	293	487	494
Poplar Ward (CAMHS)	5	1	1	7	70	69	277	416	423
Ardleigh Ward	8	6	1	15	174	63	94	331	346
Peter Bruff Ward	3	4	6	13	78	49	97	224	237
Chelmer Ward	1	-	-	1	78	45	25	148	149
Assessment Unit - Grangewaters	1	-	-	1	30	45	42	117	118
Willow Ward	1	1	2	4	12	62	38	112	116
Galleywood Ward	1	1	1	3	20	46	41	107	110
Cherrydown Ward	-	-	1	1	-	22	84	106	107
Christopher Unit (PICU)	4	1	1	6	25	51	8	84	90
Topaz Ward	-	1	-	1	-	19	70	89	90
Fuji	-	-	2	2	9	5	48	62	64
Hadleigh Unit (PICU)	-	1	-	1	7	18	25	50	51
Grangewaters Ward	1	-	-	1	13	6	16	35	36
Causeway	-	-	-	-	20	3	6	29	29
Health Based Place of Safety (HBPoS) – x 4 Sites	-	-	-	-	6	5	18	29	29
Cedar Ward	-	-	1	1	18	2	2	22	23
Kelvedon Ward	-	-	1	1	2	11	7	20	21
Finchingfield Ward	-	1	1	2	2	4	8	14	16
Stort Ward	-	-	1	1	5	2	5	12	13
Thorpe Ward	-	-	-	-	5	7		12	12
Gosfield Ward	-	-	1	1	1	-	8	9	10
Rainbow Unit	-	-	-	-	9	1	-	10	10
Edward House	-	-	-	-	1	-	5	6	6
Roding Ward	-	1	1	2	1	2	-	3	5
Henneage Ward	1	-	-	1	2	1	-	3	4
Ruby Ward	-	-	-	-	2	-	2	4	4
Wood Lea Clinic	-	-	-	-	1	-	3	4	4
Byron Court	-	-	-	-	-	-	3	3	3
Gloucester Ward	-	-	1	1	-	-	1	1	2
Beech Ward (Rochford)	-	1	-	1	-	-	-	-	1
Meadowview Ward	-	-	-	-	1	-	-	1	1
Tower Ward	-	-	-	-	-	-	1	1	1

The chart below details incidents by the highest reporting wards for secured ligatures from April 2020 to March 2023.There were a total of 88 secured ligatures reported during the period.



There were 1,494 reported unsecured ligature incidents during 2022/23. Larkwood Ward was the highest reporting unit, accounting for 19.6% of the incidents during 2022/23.



4.1 Ward Trend Analysis

Following clinical operational staff consultation, the increase in unsecured incidents, particularly on Ardleigh, Peter Bruff, Cherrydown, Topaz and Fuji wards, may be attributed to the nature of the wards, which encompasses the following:

1. Periods of high reporting related to acuity of particular admitted patients;
2. Increase in admissions, including patients who require enhanced levels of engagement and supportive observations due to the risks of self-harming and active suicidal ideation;
3. Patients with longer length of stay due to the complex nature of their presentation, but also continuing to present as high risk;
4. Length of stay on assessment unit waiting for a treatment bed;
5. A high number of patients with particular diagnoses that lends themselves to riskier behaviours;
6. Patients copying self-harming behaviours off each; and
7. Extremely high ward activity.

Services continue to take an MDT approach to management of self-harming by ligature. Safety huddles and effective handovers are utilised by wards to address any immediate patient safety issues. The MDT discusses longer term plans, reviews treatment plans and strategies that will allow eventual safe discharge. Enhanced engagement and supportive observations are prescribed where necessary and reviewed regularly to reduce restrictive practice.
Where comorbidities and complexities exist, professionals meetings that have a wide representation from the MDT will consider all aspects of patient care, reviewing Datix themes and create strategies for safe alternatives.

Staff development in management of self-harming remains imperative in supporting the Trust's safety strategy. Such development includes Dialectical Behaviour Therapy (DBT) informed practice training that staff can access.

The significant decrease in unsecured incidents noted on Christopher Unit is due to the refurbishment works that took place. For a significant period while the refurbishment works were being undertaken, the PICU was admitting males only. It is expected that as the works have been completed and the unit has now opened the female beds, an increase may be seen. Also to note is that the PICU admission criteria has changed in line with the national PICU standards and framework. The criteria excludes patients with a standing diagnosis of personality disorder.

Building resilience for staff and families in the response to ligature related incident is imperative so that staff remain calm, supportive and non-punitive. This is the essential in the preservation of therapeutic relations and the shared ability to cope with the trauma and challenges such incidents bring. Reflective practice, debriefs and supervision remain key for staff, alongside the development of training and support for families and carers.

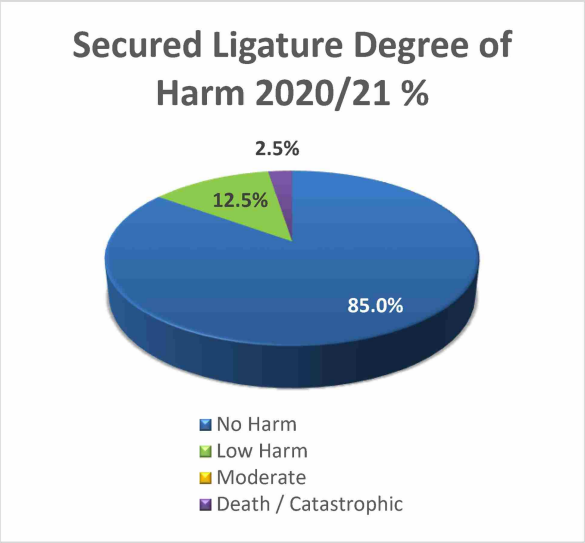
5.0 Incidents by Degree of Harm

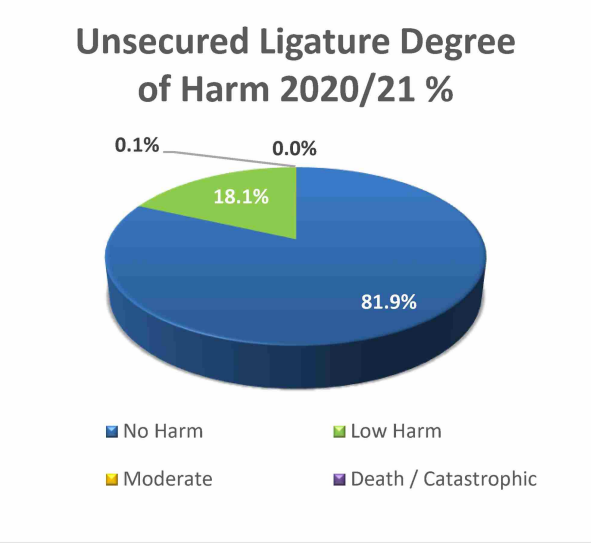
The table below details the reported outcome/degree of harm to the patient as a result of the incidents as recorded on Datix. Over the three year period, 85.9% of incidents have had a reported outcome of no harm.

Immediate learning has prompted changes in practice, particularly the way observations are carried out and documented.

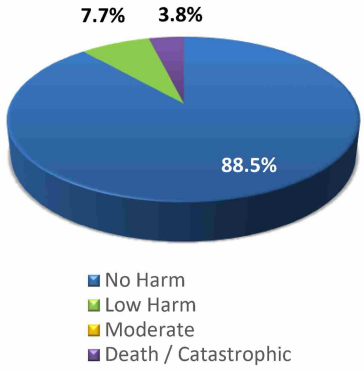
Ligature Incidents -Degree of Harm	2020/21	2021/22	2022/23	Total
Secured	**35**	**26**	**29**	**90**
No Harm	29	23	26	78
Low Harm	5	2	1	8
Moderate	-	-	2	2
Death / Catastrophic	1	1	-	2
Unsecured	**1149**	**1084**	**1496**	**3729**
No Harm	957	1003	1274	3234
Low Harm	191	77	220	488
Moderate	1	3	2	6
Death / Catastrophic	-	1	-	1
Grand Total	**1184**	**1110**	**1525**	**3819**

The pie charts below detail the percentage of each recorded degree of harm, by financial year and secured/unsecured ligature. For reference, charts have also been added to reflect the whole three period covered by this report.

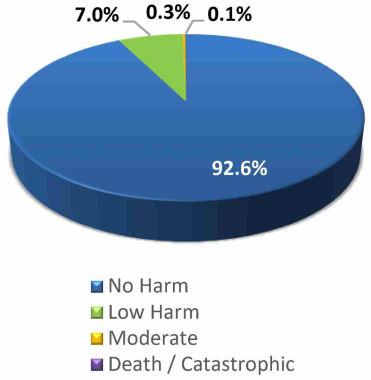




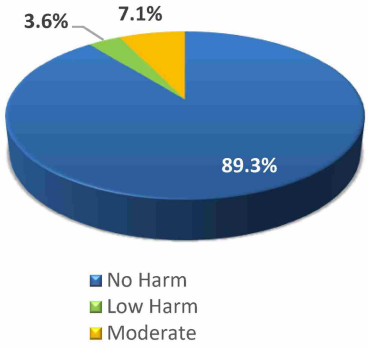
Secured Ligature Degree of Harm 2021/22 %



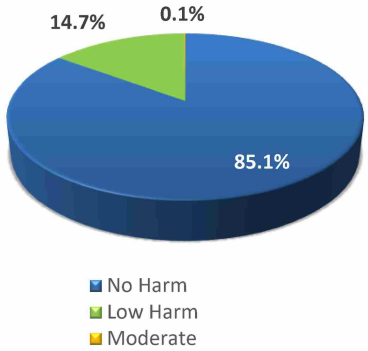
Unsecured Ligature Degree of harm 2021/22 %



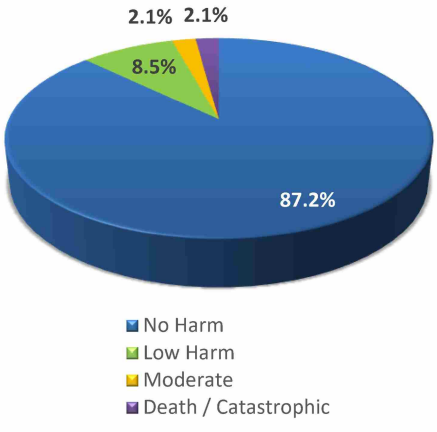
Secured Ligature Degree of Harm 2022/23 %



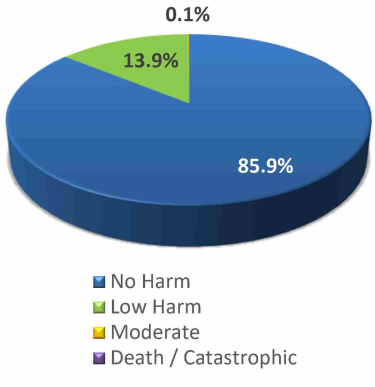
Unsecured Ligature Degree of Harm 2022/23 %



Secured Ligature Degree of Harm 2020/21 - 2022/23 %



Unsecured Ligature Degree of Harm 2020/21 - 2022/23 %



6.0 Items used to Ligature

Items of bedding have consistently remained the highest reported ligature for secured ligatures, and it should be noted this is increasing year on year as detailed below:

- 46.4% of all secured ligature incidents during 2022/23, compared to 38.5% during 2020/21 and 20.0% during 2020/1

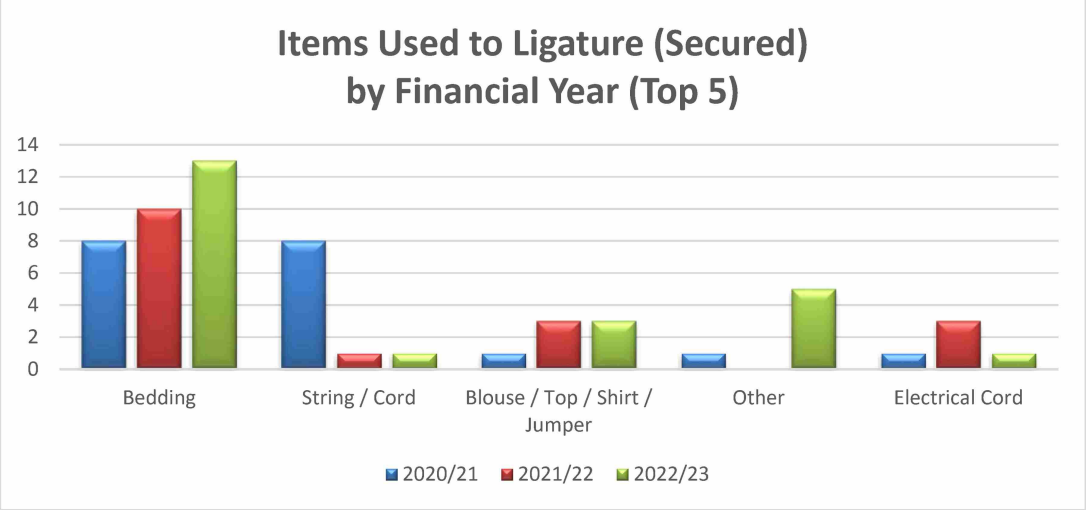
Conversely, bedding being used for unsecured ligatures is reducing year on year:

- 9.6% of all unsecured ligature incidents during 2022/23, compared to 15.1% during 2020/21 and 16.7% during 2020/21.

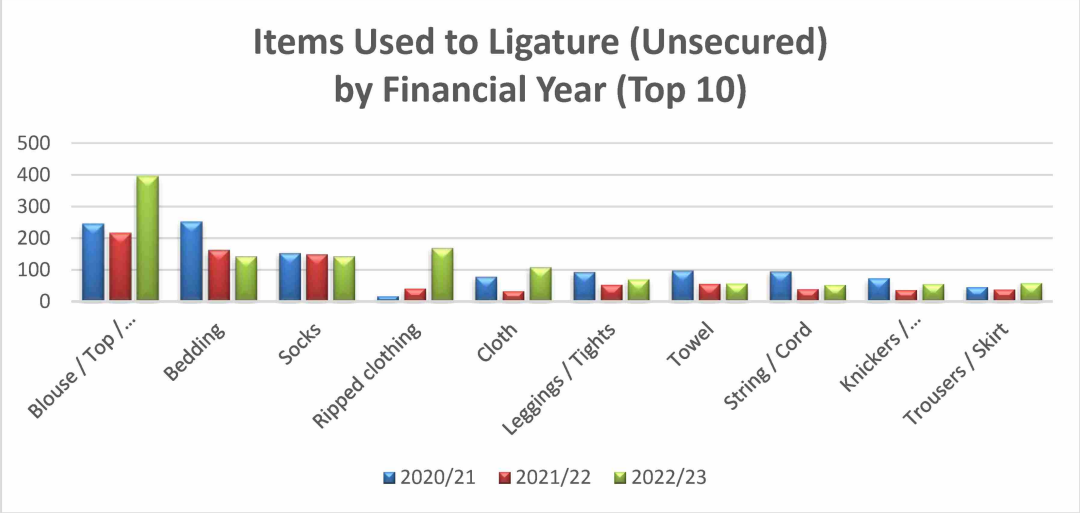
Items of clothing, (specifically Blouses/Tops/Shirts/Jumpers) are the highest reported ligature for non-secured ligatures and are also showing an increasing trend:

- 26.6% of all secured ligature incidents during 2022/23, compared to 19.9% during 2021/22 and 16.2% during 2020/21.

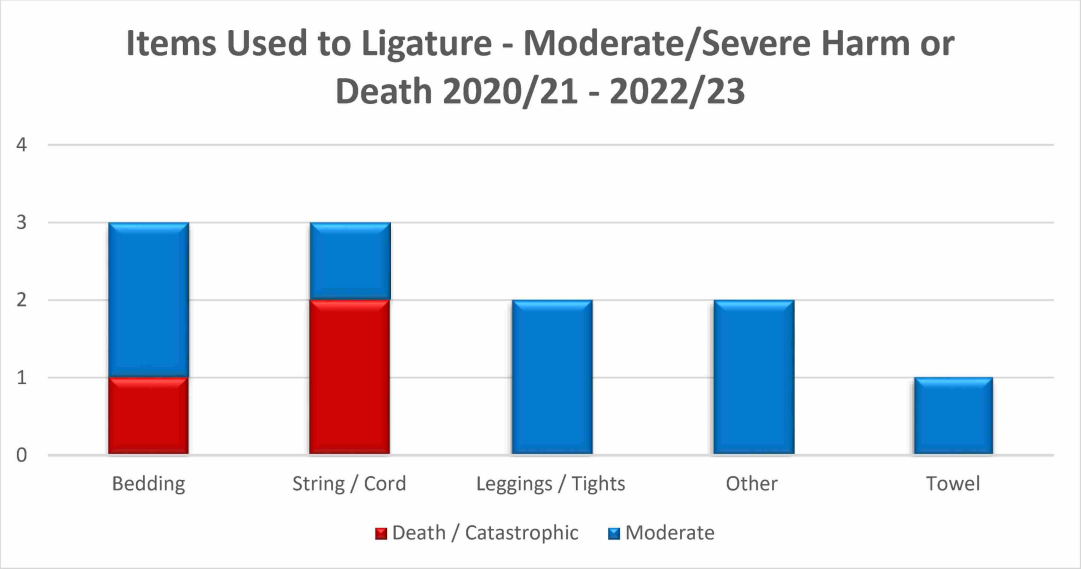
The graph below details the top five reported items used to ligature (Secured) across the period.



The graph below details the top 10 reported items used for unsecured ligature.



The graph below details the items used to ligature which resulted in moderate or above harm



7.0 Anchor Points used to Secure Ligature

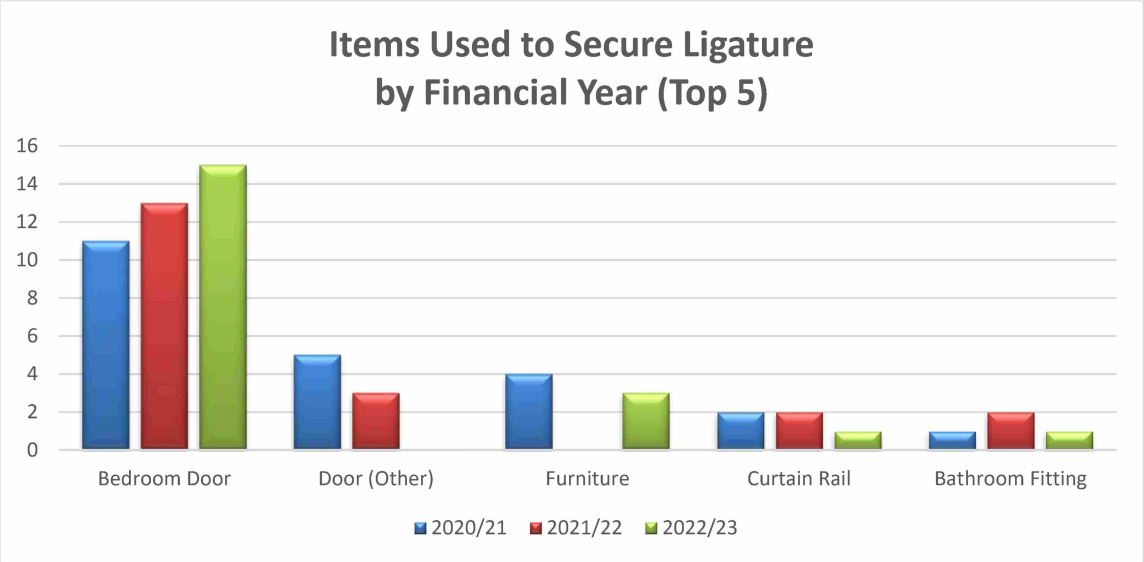
Bedroom doors remain the most used anchor point accounting for 44.3% of anchor points used across the three period. However analysis shows that the resulting harm is no/low harm. Items used to secure a ligature which have resulted in an outcome of moderate harm or above are detailed below:

- Bathroom Fitting (1 x death)
- Bed (1 x death)
- Furniture (1 x moderate)
- Tree (1 x moderate) – Not on EPUT premises (Informal patient on leave from Ardleigh Ward)

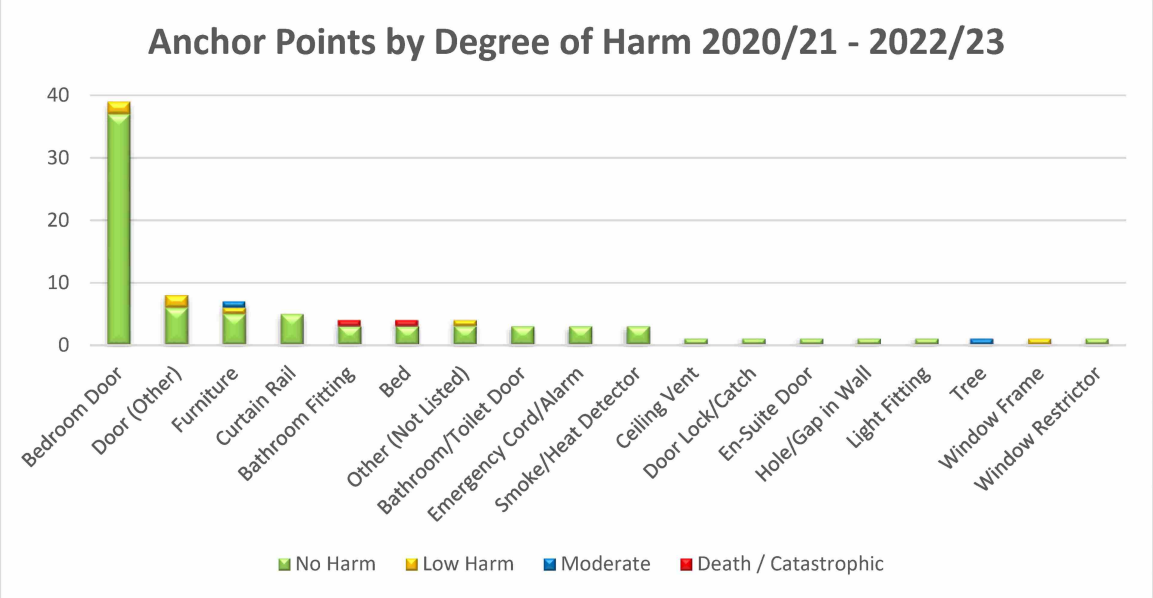
The table below details the items used to secure a ligature.

Anchor Points	2020/21	2021/22	2022/23	Total
	34	26	28	88
Bedroom Door	11	13	15	39
Door (Other)	5	3	-	8
Furniture	4	-	3	7
Curtain Rail	2	2	1	5
Bathroom Fitting	1	2	1	4
Bed	1	1	2	4
Other (Not Listed)	1	2	1	4
Bathroom/Toilet Door	-	2	1	3
Emergency Cord/Alarm	1	-	2	3
Smoke/Heat Detector	3	-	-	3
Ceiling Vent	-	1	-	1
Door Lock/Catch	1	-	-	1
En-Suite Door	1	-	-	1
Hole/Gap in Wall	1	-	-	1
Light Fitting	1	-	-	1
Tree	-	-	1	1
Window Frame	1	-	-	1
Window Restrictor	-	-	1	1

The graph below details the top five reported items used to secure a ligature.



The graph below reviews commonly used anchor points and level of harm



8.0 Technical Innovation

8.1 Door Top Alarms

Further analysis has been undertaken on incidents involving doors as bedroom doors are the top reported anchor point. Door top alarms (DTAs) were recorded as being in place for 76.5% of incidents during 2020/21 compared to 100% in 2021/22 and 2022/23.

The table below details the total number of incidents reported.

Total Number of Incidents	2020/21	2021/22	2022/23	Total
	17	18	16	51
% Door Top Alarms in Place	**76.5%**	**100%**	**100%**	**92.2%**
Door Top Alarm in Place	**13**	**18**	**16**	**47**
Ardleigh Ward	1	5	-	6
Cedar Ward	-	-	1	1
Christopher Unit (PICU)	2	1	1	4
Finchingfield Ward	-	-	1	1
Galleywood Ward	1	1	1	3
Gosfield Ward	-	-	1	1
Larkwood Ward	2	-	3	5
Longview Ward	3	6	2	11
Peter Bruff Ward	2	4	4	10
Poplar Ward (CAMHS)	1	-	-	1
Topaz Ward	-	1	-	1
Willow Ward	1	-	2	3
Door Top Alarm NOT in Place	**4**	**-**	**-**	**4**
Ardleigh Ward	2	-	-	2
Poplar Ward (CAMHS)	2	-	-	2

8.2 OxeVision

Analysis has been undertaken looking at wards where OxeVision has been installed to see if this has had an impact on ligature incident numbers. The trend indicator is based on the overall numbers of incidents since OxeVision was installed. Please note there are nine units (ten including the various HBPoS') which do not currently have OxeVision installed resulting in no trend analysis being possible.

Ward	Date OxeVision Installed	Secured			Unsecured			Trend
		2020/21	2021/22	2022/23	2020/21	2021/22	2022/23	
Ardleigh Ward	03/04/2020	8	6	1	174	63	94	↓
Assessment Unit - Grangewaters	07/07/2021	1	-	-	30	45	42	↓
Beech Ward (Rochford)	01/07/2021	-	1	-	-	-	-	→
Byron Court	N/A	-	-	-	-	-	3	N/A
Causeway	N/A	-	-	-	20	3	6	N/A
Cedar Ward	11/05/2021	-	-	1	18	2	2	↓
Chelmer Ward	04/08/2020	1	-	-	78	45	25	↓
Cherrydown Ward	23/09/2021	-	-	1	-	22	84	↑
Christopher Unit (PICU)	23/03/2021	4	1	1	25	51	8	↓
Edward House	N/A	-	-	-	1	-	5	N/A
Finchingfield Ward	11/02/2021	-	1	1	2	4	8	↑
Fuji	N/A	-	-	2	9	5	48	N/A
Galleywood Ward	15/02/2021	1	1	1	20	46	41	↓
Gloucester Ward	27/09/2021	-	-	1	-	-	1	→
Gosfield Ward	29/04/2021	-	-	1	1	-	8	↑
Grangewaters Ward	07/07/2021	1	-	-	13	6	16	↑
Hadleigh Unit (PICU)	30/10/2020	-	1	-	7	18	25	↑
Health Based Place of Safety (HBPoS)	N/A	-	-	-	6	5	18	N/A
Henneage Ward	16/07/2021	1	-	-	2	1	-	↓
Kelvedon Ward	07/12/2021	-	-	1	2	11	7	↓
Larkwood Ward	15/02/2021	4	-	3	96	98	293	↑
Longview Ward	15/02/2021	4	7	3	462	448	267	↓
Meadowview Ward	N/A	-	-	-	1	-	-	N/A
Peter Bruff Ward	30/10/2020	3	4	6	78	49	97	↑
Poplar Ward (CAMHS)	15/03/2021	5	1	1	70	69	277	↑
Rainbow Unit	N/A	-	-	-	9	1	-	N/A
Roding Ward	23/09/2021	-	1	1	1	2	-	↓
Ruby Ward	13/07/2021	-	-	-	2	-	2	→
Stort Ward	21/04/2021	-	-	1	5	2	5	↑
Thorpe Ward	N/A	-	-	-	5	7	-	N/A
Topaz Ward	09/06/2021	-	1	-	-	19	70	↑
Tower Ward	N/A	-	-	-	-	-	1	N/A
Willow Ward	11/05/2021	1	1	2	12	62	38	↑
Wood Lea Clinic	N/A	-	-	-	1	-	3	N/A
Total		**34**	**26**	**28**	**1150**	**1084**	**1494**	

Ward	Date OxeVision Installed	20/21				21/22				22/23		
		No Harm	Low Harm	Mod Harm	Death	No Harm	Low Harm	Mod Harm	Death	No Harm	Low Harm	Mod Harm
Ardleigh Ward	03/04/2020	148	34	-	-	64	5	-	-	87	7	1
Assessment Unit - Grangewaters	07/07/2021	24	7	-	-	41	4	-	-	39	3	-
Beech Ward (Rochford)	01/07/2021	-	-	-	-	-	-	-	1		-	-
Byron Court	N/A	-	-	-	-	-	-	-	-		3	-
Causeway	N/A	18	2	-	-	3	-	-	-	6	-	-
Cedar Ward	11/05/2021	11	7	-	-	2	-	-	-	3	-	-
Chelmer Ward	04/08/2020	67	12	-	-	44	1	-	-	24	1	-
Cherrydown Ward	23/09/2021	-	-	-	-	19	3	-	-	78	6	1
Christopher Unit (PICU)	23/03/2021	24	5	-	-	50	2	-	-	7	2	-
Edward House	N/A	-	1	-	-	-	-	-	-	5	-	-
Finchingfield Ward	11/02/2021	-	2	-	-	5	-	-	-	8	1	-
Fuji	N/A	8	1	-	-	5	-	-	-	50	-	-
Galleywood Ward	15/02/2021	17	4	-	-	21	25	1	-	29	13	-
Gloucester Ward	27/09/2021	-	-	-	-	-	-	-	-	2	-	-
Gosfield Ward	29/04/2021	1	-	-	-	-	-	-	-	9	-	-
Grangewaters Ward	07/07/2021	8	6	-	-	6	-	-	-	13	2	1
Hadleigh Unit (PICU)	30/10/2020	6	1	-	-	17	2	-	-	17	8	-
Health Based Place of Safety (HBPoS)	N/A	6	-	-	-	5	-	-	-	13	5	-
Henneage Ward	16/07/2021	1	1	-	1	1	-	-	-		-	-
Kelvedon Ward	07/12/2021	2	-	-	-	11	-	-	-	6	1	1
Larkwood Ward	15/02/2021	88	11	1	-	89	8	1	-	282	14	-
Longview Ward	15/02/2021	397	69	-	-	443	10	1	1	262	8	-
Meadowview Ward	N/A	1	-	-	-	-	-	-	-		-	-
Peter Bruff Ward	30/10/2020	72	9	-	-	49	4	-	-	102	1	-
Poplar Ward (CAMHS)	15/03/2021	59	16	-	-	66	4	-	-	142	136	-
Rainbow Unit	N/A	6	3	-	-	1	-	-	-		-	-
Roding Ward	23/09/2021	1	-	-	-	3	-	-	-	1	-	-
Ruby Ward	13/07/2021	2	-	-	-	-	-	-	-	2	-	-
Stort Ward	21/04/2021	3	2	-	-	2	-	-	-	5	1	-
Thorpe Ward	N/A	5	-	-	-	7	-	-	-		-	-
Topaz Ward	09/06/2021	-	-	-	-	17	3	-	-	66	4	-
Tower Ward	N/A	-	-	-	-	-	-	-	-	1	-	-
Willow Ward	11/05/2021	11	2	-	-	55	8	-	-	35	5	-

Wood Lea Clinic	N/A	1	-	-	-	-	-	-	-	3	-	-
Total		**987**	**195**	**1**	**1**	**1026**	**79**	**3**	**2**	**1297**	**221**	**4**

On wards where OxeVision has been installed, it is the responsibility of the reporter to record on the Datix report if staff were alerted by the system, using the field shown below which provide the following options:

- Yes
- No
- N/A (To this incident)



The table below provides details of the top ten reporting wards (Self-Harm/Ligature), including the number of incidents recorded where staff were alerted by OxeVision. Please note, the total row includes data for all of the remaining wards which are not shown in the table.

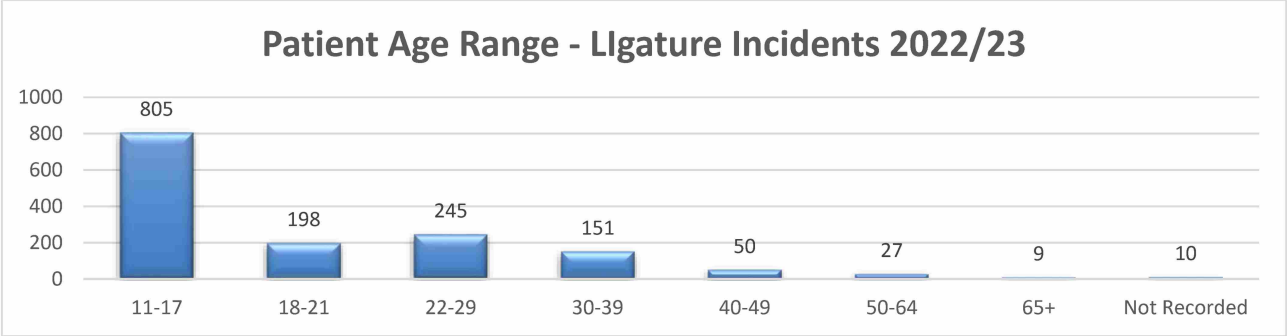
Ward Name	20/21 OxeVision Alerted Staff	% noting OxeVision in Datix	20/21 Ligature Incidents	21/22 OxeVision Alerted Staff	% noting OxeVision in Datix	21/22 Ligature Incidents	22/23 OxeVision Alerted Staff	% noting OxeVision in Datix	22/23 Ligature Incidents	Total
	93	**7.9%**	**1184**	**138**	**12.4%**	**1110**	**180**	**11.8%**	**1525**	**3819**
Longview Ward	2	0.4%	467	68	14.9%	455	40	14.8%	270	1192
Larkwood Ward	-	0.0%	100	19	19.4%	98	47	15.8%	297	495
Poplar Ward (CAMHS)	2	2.7%	75	6	8.6%	70	34	12.2%	278	423
Ardleigh Ward	70	38.5%	182	16	23.2%	69	14	14.7%	95	346
Peter Bruff Ward	10	12.3%	81	5	9.4%	53	13	12.6%	103	237
Chelmer Ward	9	11.5%	78	11	24.4%	45	3	12.0%	25	148
Assessment Unit - Grangewaters	-	0.0%	31	-	0.0%	45	2	4.8%	42	118
Willow Ward	-	0.0%	13	1	1.6%	63	-	0.0%	40	116
Galleywood Ward	-	0.0%	21	2	4.3%	47	1	2.4%	42	110
Cherrydown Ward	-	-	-	-	0.0%	22	9	10.6%	85	107

9.0 Recurring Incidents 2022/23

From 01/04/2022 – 31/03/2023 there was a total of 1525 reported incidents of self-harm by unsecured ligature that occurred within EPUT inpatient settings. Taking into account where the same patient is involved in a number of the reported incidents, the 1525 identified incidents are apportioned to 206 individual patients.

10.0 Age of Patients (2022/23)

The CAMHS inpatient units, reported the highest number of ligature incidents during 2022/23, which is reflected in the age ranges of the patients affected. 53.8% of the total number of reported incidents involved 11 - 17 year olds as shown by the chart and table below.
*Please note the total number of incidents detailed in the tables below is 1495. This is lower than the total number of incidents recorded due to some of the Datix reports not including the names of the patients involved. This issue is addressed via training and managers have a responsibility to update/add any details missing from a reported incident prior to sign off.



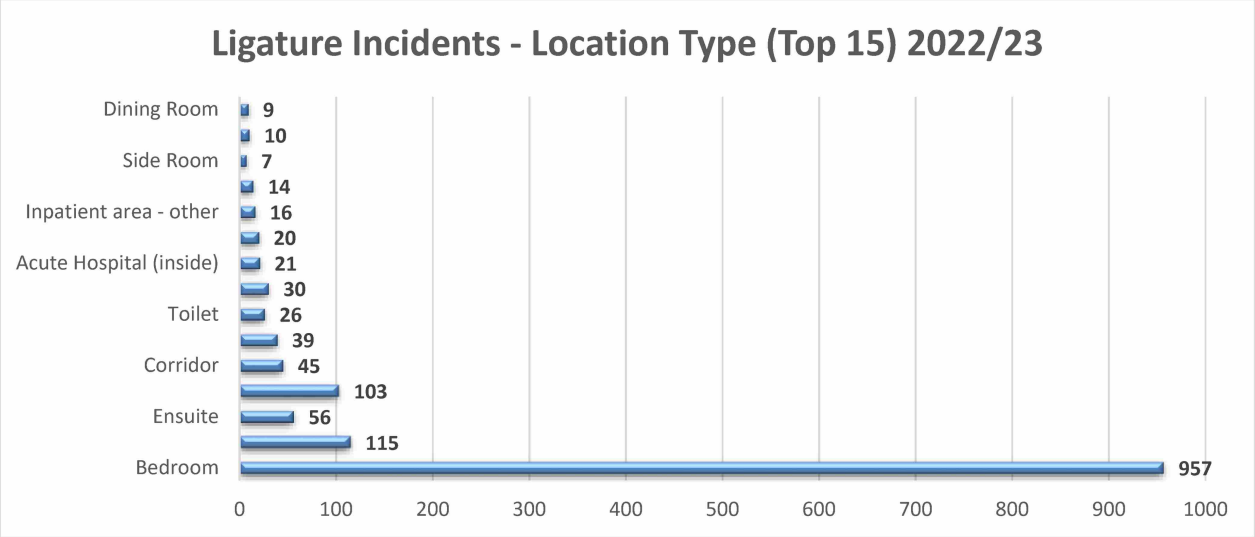
Age Range – Inpatient Ligature Incidents 2022/23	Age Range	% of total*
11-17	805	53.8%
18-21	198	13.2%
22-29	245	16.4%
30-39	151	10.1%
40-49	50	3.3%
50-64	27	1.8%
65+	9	0.6%
Not Recorded	10	0.7%
Total*	**1495**	

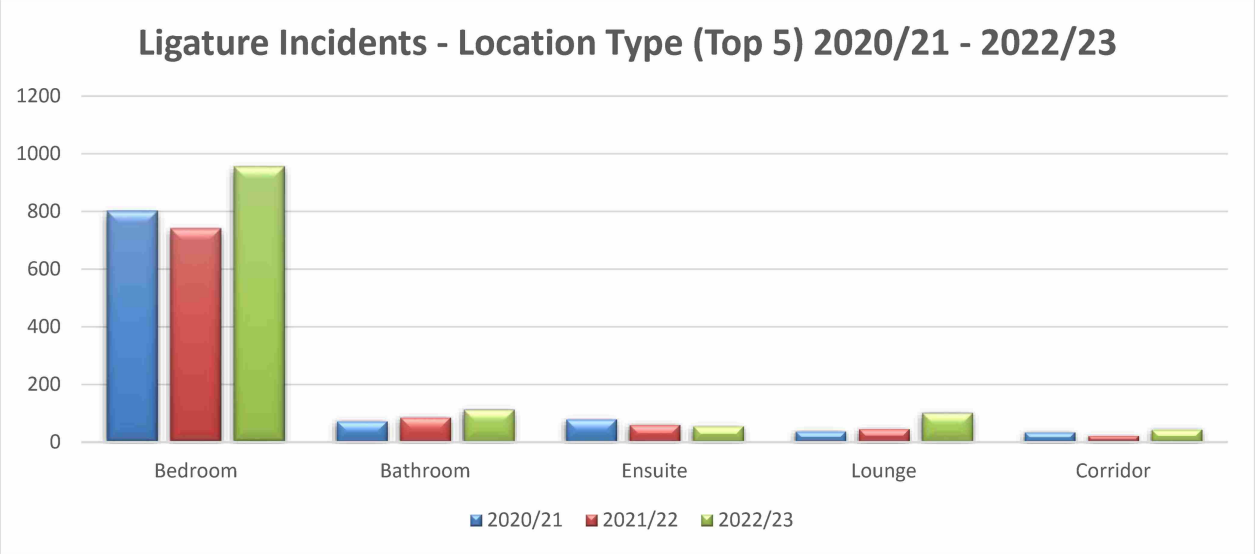
11.0 Gender

Data has shown that 85.5% (1254) ligature incidents involved female patients compared to 8.4% (123) involving male patients. A further 90 incidents were reported where the gender was recorded as “Other” with the remaining incidents not recording the gender. This is primarily due to the incidents in which the patient details have not been recorded.

12.0 Specific Location of Incidents

957 incidents were reported during 2022/23 were recorded as having occurred in patients bedrooms, which equates to 62.8% of the total incidents. The charts below detail the highest 15 reported location types during 2022/23 and the top 5 locations across the three year period covered by this report.

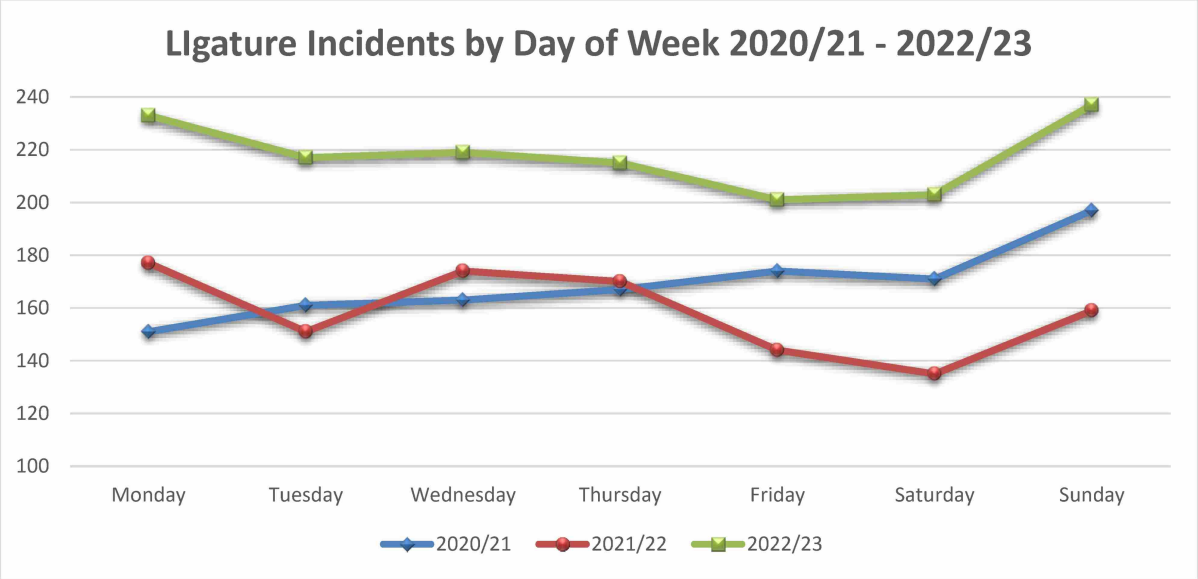




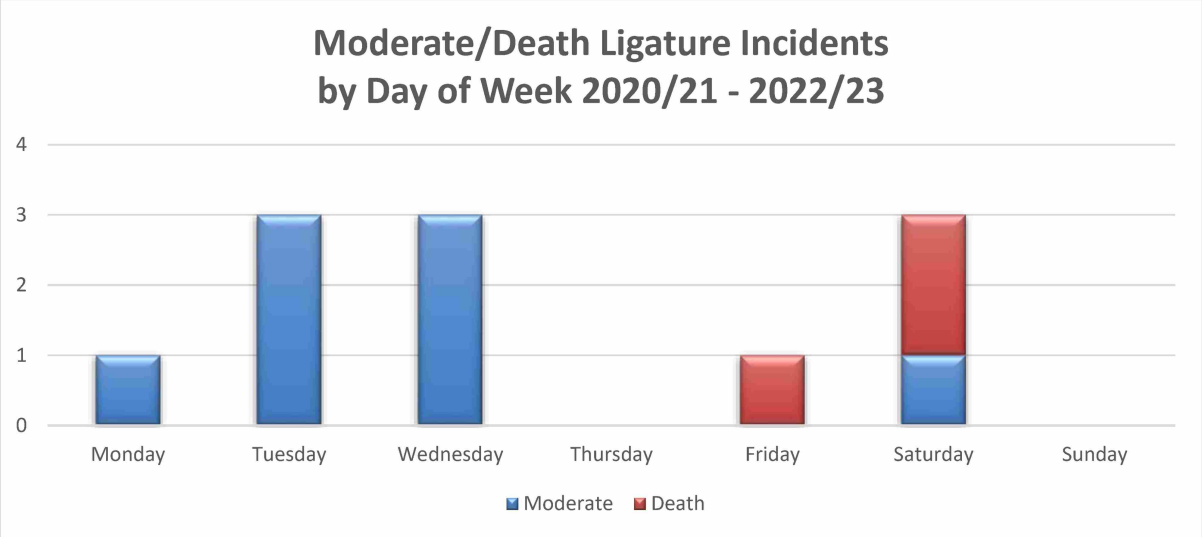
13.0 Day of the Week

A review of incidents from 01/04/2020 – 31/03/2023 has been undertaken looking at which days of the week ligature incidents have taken place on EPUT's inpatient wards. The highest reporting days are Sunday and Monday and the lowest Friday and Saturday. This remains consistent with finding in previous reports. Further analysis was undertaken to consider degree of harm by day which found Tuesdays, Wednesdays and Saturdays to be the days on which incidents resulted in moderate harm or death. Please note, no incidents resulting in severe harm were recorded during the period.

The graphs below provide visual representations of this data.



The graph below provides the number of incidents resulting in moderate harm or death by the day of the week.

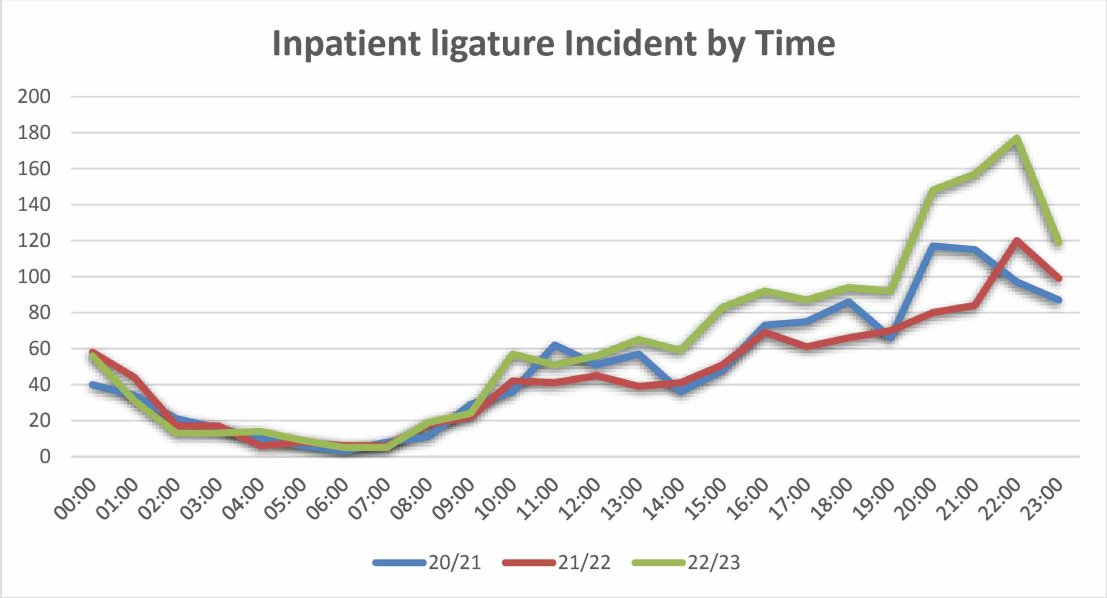


Discussion with clinical operational staff highlighted that times of day and day of the week seem to be important with correlations to key events such as discharge, care reviews, hearings etc. Services need to be mindful of this in risk management planning and providing support as well as increased vigilance in the run up to these.

14.0 Time of Incidents

A review of incidents from 01/04/2020 – 31/03/2023 has been undertaken looking at the times of ligature incidents and from the data it is evident that the number of incidents significantly increase as the day progresses with a slight decrease shown at lunch time. The rate of incidents peaks between the hours of 20:00 to midnight.

The graph below shows the time of ligature incidents (by hour) and indicates similar patterns across the three year period. However, an increase is noted to have occurred between the hours of 20.00 – 22.00 during 2022/23 in comparison to the two previous financial years.



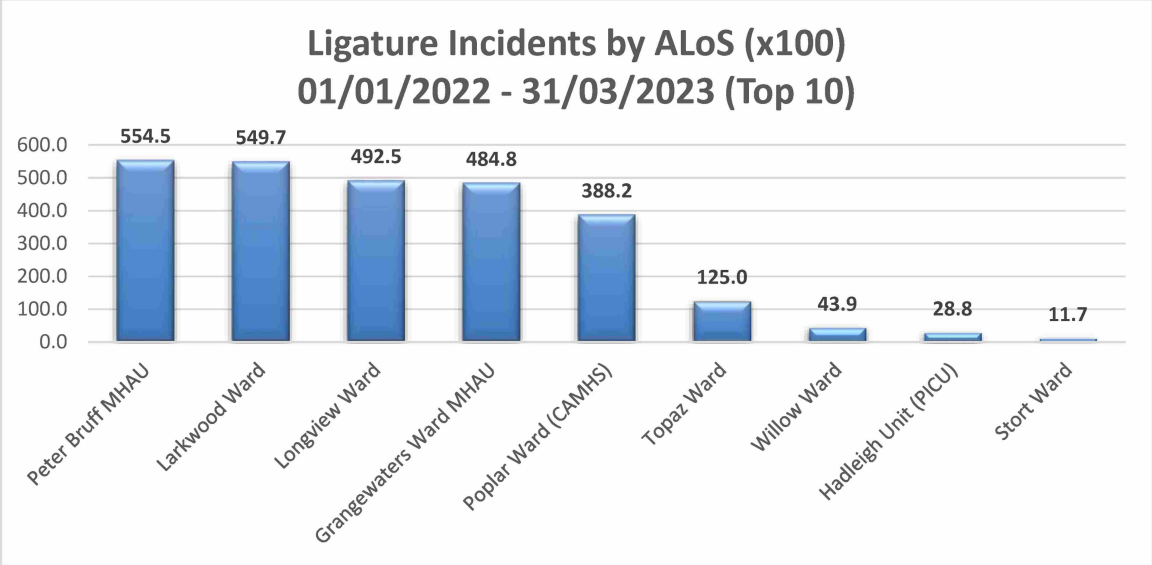
15.0 Average Length of Stay (ALoS)

Analysis has been undertaken to establish if there is a correlation between the average length of stay (ALoS) per ward and the number of ligature incidents recorded. The chart below shows the number of ligature incidents by ward (top 10), by an average of 100 day length of stay for the period 01/01/2022 – 31/03/2023.

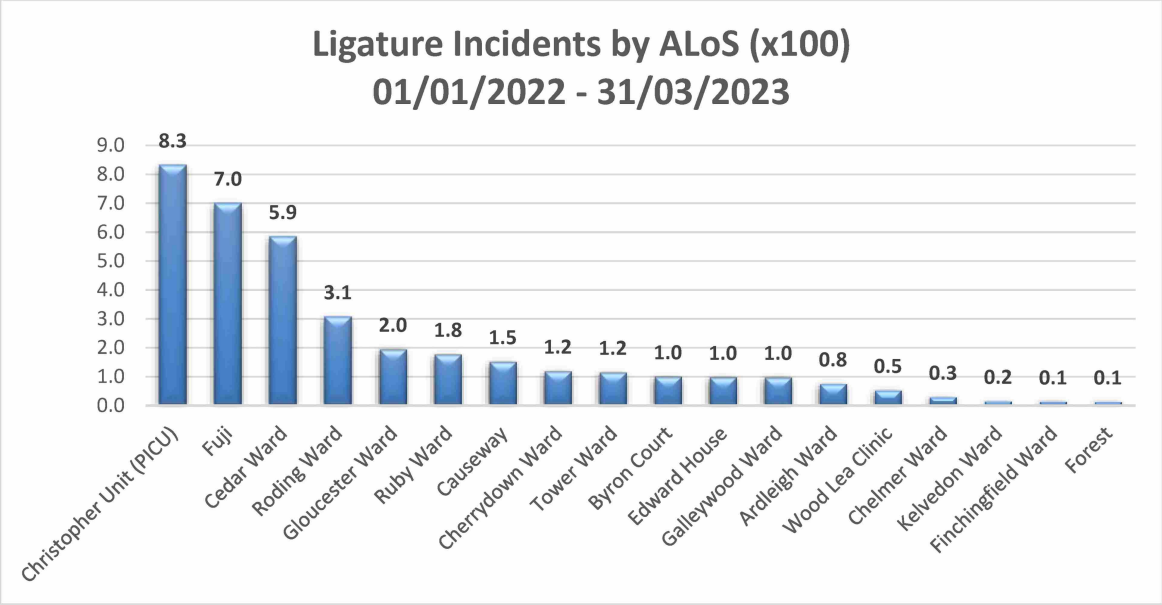
As expected, the CAMHS inpatient units are included in the top 10, however the two Assessment Units are also reporting a high number of ligature incidents per ALoS. Peter Bruff reported 112 incidents against an ALoS for the period of 20 and were the highest reporting unit using this metric.

The two PICU's are also present in the top 10 reporting wards, with Hadleigh Unit reporting 36 incidents (125 day ALoS) and Christopher Unit 12 incidents (144 day ALoS).

None of the top 10 highest reporting units, were in the top 10 for ALoS. The top 10 was comprised of Secure Services, which is to be expected due to the nature of the services provided. However, only Willow Ward and Stort Ward were in the top 15 which indicates no specific link to the number of incidents by length of stay. The service provided is clearly more indicative or a risk to patient safety by ligature.



The reporting rates for the remaining units are shown in the chart below.



16.0 Incident recording – Death category

It has been noted there are incidents that resulted in a patient's death, which have been recorded on the Datix system under the 'Death' category, not 'Self-Harm' (Ligature). These incidents were excluded from the data contained in the main body of this report, due to the lack of additional information recorded under this category, e.g. if ligature was secured; what was used to ligature etc.

The recommendation for incident reporting is for any incident involving a patient self-harming, being recorded under the 'Self-Harm' category, regardless of the outcome. The outcome should then be recorded as one of the following as per the Trusts Incident Reporting Policy (CP3):

- No harm
- Low harm
- Moderate harm
- Severe harm
- Death

This section has been added to provide an overview of incidents in which a patient died as a result of self-harming by ligature, recorded under the 'Death' category. Please note the six incidents in question have now been amended and recorded under the 'Self-Harm (Ligature) category/sub-category.

Ligature Deaths (Category)	2021/22	2022/23	Total
Beech Ward (Rochford)	1	-	1
Chelmer Ward	-	1	1
Forest	-	1	1
Gloucester Ward	-	1	1
Longview Ward	1	-	1
Willow Ward	-	1	1
Total	**2**	**4**	**6**

The table below provides an overview of the six incidents. There is no specific correlation between the incidents, with 50% involving secured ligatures.

Ward	Date	Time	Secured Ligature?	Item used to secure Ligature	Item used to Ligature
Longview Ward	17/04/2021	18.40	No	N/A	Bedding
Beech Ward (Rochford)	18/12/2021	10.58	Yes	Hand Rail	Trouser Cord
Gloucester Ward	24/05/2022	20.50	Yes	Profile Bed	Dressing Gown Cord
Chelmer Ward	06/07/2022	16.12	No	N/A	Material Belt
Willow Ward	19/08/2022	17.30	No	N/A	Socks
Forest Ward	08/01/2023	12.22	Yes	Bedroom Door	Bedding

17.0 Conclusions

The data indicates the numbers of incidents in which a secured ligature has been used by patients to self-harm remains relatively low in comparison to those which are unsecured, across all inpatient services provided by the Trust. This can be attributed to an increased awareness of the risks involved and the ongoing work in improving the ward environments to mitigate the risk of patients securing a ligature.

However, whilst the risk of significant harm or death is lower where a ligature is unsecured, there have been 10 incidents reported as resulting in moderate harm or death over the three year period covered by this report. It is vital that all staff retain an awareness of the risk to patient safety and that all relevant procedures are followed and lessons learned and actions taken and embedded in practice where appropriate.

Where a ligature has been secured, the highest reported item used as the anchor point, has been doors. This risk has been mitigated by the Trusts use of technology with the introduction of door top alarms and OxeVision in patient bedrooms. All incidents reported between 2021/22 – 2022/23 noted a door top alarm was in place and OxeVision continues to be rolled out across the Trusts inpatient units. Whilst this helps staff to manage the level of risk, it is unclear how effective OxeVision is due to the low reporting numbers. During 2022/23, only 11.8% of all ligature incidents, recorded OxeVision as having alerted staff. All staff should be reminded of the importance of accurate recording of incidents on Datix to ensure we are able to monitor the data to identify and trends or patterns which may help to improve patient safety.

The three CAMHS inpatient units are consistently the highest reporters of ligature incidents, accounting for 55.2% of the Trust total. This is also reflected by the age of patients involved in ligature incidents, with 53.8% being in the 11/17 years range.

A high proportion of patients involved in using ligatures were female, accounting for 85.5% of the total reported during 2022/23.

Incidents are more likely to occur between the hours of 20.00 – 22.00 across the inpatient areas, indicating an increased risk at quieter times, after dinner, when activities have ceased and when patients will be retiring to bed. Whilst there is no direct correlation between the severity of the outcome and the time the incident took place, it should be noted by clinical leads to be mindful of this to ensure appropriate actions are taken to reduce the risk of self-harming behaviours.

The analysis of incidents against the average length of stay, indicated the type of service care provided is more likely to influence the numbers of ligature attempts made by patients.

As noted in the introduction to this report, it was highlighted a number of incidents had been reported on Datix using the 'Death' category' as opposed to 'Self-Harm'. Whilst it is understandable why staff may feel this is appropriate, it is important that any incident of a patient using a ligature is recorded under 'Self-Harm' (sub-category 'Ligature') as this will record the details including what was used to ligature, if the ligature was secured etc. Datix handlers/managers should remain mindful of their responsibility to ensure incidents are recorded appropriately with the correct information and if support is required, to contact the Datix Team/Ligature Co-Ordinator.

Report Prepared by

[I/S]
Senior Datix Manager
on behalf of

Nicola Jones
Director of Risk and Compliance

September 2023