Staffing and skills

The importance of an appropriately skilled and resourced workforce to minimise the risk of harm is not a new concept, but one that is enshrined in both regulatory and quality improvement requirements.

There are relatively few studies of patient safety in a mental health inpatient context, particularly those concerned with workforce and the impact on risk reduction in ligature-related harm.

Developing and retaining a confident, competent and psychologically robust workforce are key enablers of the interventions described in this guidance.

To understand the importance of the relationship between workforce issues and reducing ligature risks in built environments, we must first understand the broader challenges of workforce development.

In 2017, the Health Education England report Stepping forward to 2020/21 estimated that NHS organisations lose 10,000 staff each year from mental health services. Staff leaving is often associated with poorer quality of care, which in turn may lead to an increase in self-harm, including ligature-related incidents.

Health Education England published competence frameworks for self-harm and suicide prevention in adults and older adults, and for children and young people, recommending skills and knowledge for professionals across a broad range of backgrounds and experiences, including professionals and volunteers who work in mental health, physical health and social care.

Skill mix

In 2016 the National Quality Board highlighted the importance of evidence-based staffing skill mixes in mental health settings.

Defining the ratio of both registered and unregistered staff to patients, other professionals (for example, psychologists and occupational therapists), and other team members (such as peer support workers and physicians' associates) and the wider multidisciplinary team (MDT) input are key to successful workforce skill mix.

Staffing numbers need to be agreed based on current acuity, environment, enabling access to specific treatments, infection prevention and control (IPC) requirements, time of day, and increased risk and/or observation levels in addition to bed numbers.

Education and training

There is little literature focusing on ligature risk but there has been some work on education and training in relation to suicide risk reduction.

The 2019 National Enquiry into Suicide and Safety in Mental Health Annual Report noted that staff awareness was essential in reducing risk. The implication was that training would be the medium to do this.

It would appear from the literature that education and training is one element that can increase staff awareness of self-harm and suicide risk, including by the use of ligatures.

For senior clinical and estates team members, advanced ligature training would improve understanding of the anti-ligature environment and enable safer decision making.

The Mental Health Staffing Framework provides online resources to help develop leaders' awareness of the importance of, and practicalities involved in, developing local systems for ensuring appropriate skill mix and staffing levels.

Health Education England's New roles programmes may be beneficial in covering vacancies and reducing the need for use of agency staff, which is associated with improved patient experience.

Key considerations

Do we have processes that inform us of the safe staffing ratios and skill mix as a minimum, and in response to changing needs such as acuity, infection prevention and control measures and increased risks and/or observation levels?

- How do we review the skills, knowledge, and training needs of staff in response to particular areas of work?
- How do we know the skill mix and experience of our staff in response to the areas that they work?
- What are our agreements for minimum training, skills, and standards with temporary staffing providers?

Do we have the appropriate and relevant training for managing ligature harm minimisation with our workforce?

- What training do we offer staff in relation to the management and minimisation of ligatures?

- Which staff do we offer ligature minimisation and management training to and why?
- What training do we offer staff to identify risks, behaviour, potential triggers that may indicate a person may utilise ligatures?
- What training do we offer staff in relation to responding to a ligature event?
- How frequently do we require this ligature training to be carried out? Is it mandatory? Is refresher training mandatory
- What induction awareness ligature training do we require temporary staff to do?
- How do we ensure that these skills are embedded and maintained in practice? How is this supported with the following activities:
- How is learning from incidents shared and actioned in new ways of working?
- How does learning from practice and incidents inform ligature training?

What is the available support for the wellbeing of staff following any incident involving ligatures that may have caused harm?

- What is the available support for the wellbeing of patients following any incident involving ligatures that may have caused harm?
- How, when, with and by whom are debriefs carried out?
- How do we include the management and minimisation of harm from ligatures within clinical supervision sessions?

Do we have a shared sense/standard procedure of how to carry out environment assessments to assess ligature risks and how to action these? (see the section on the built environment.)

- How do we equip/train staff how to carry out ligature assessments with the environment?
- How do we communicate the findings of environmental assessments and the required responses and actions, including the reasons why, with our staff?
- Do we know areas where ligature events may more frequently occur from our incident data? How do we clearly communicate this with staff and temporary workers?
- Do we have appropriate expertise via a champion in the team or the service? How does this person(s) interact with the workforce to provide supervision and support?

Do we actively promote and maintain a psychologically safe culture through respect, mutuality, and person-centred care? Is this promoted in the following areas:

- Actively sought in recruitment at all levels and the selection process?
- How is this included in mandatory training?
- How is this included in career monitoring and development?
- How is this included in expectations for disciplinary procedures?
- How is included in the aim and ambition of the team? How is this monitored or appraised? How do we people know about it?

- How do our processes and procedures support staff and equip staff to raise concerns, potential hazards, and risks in relation to ligature harm?