PROCEDURE FOR THE REMOVAL OF LIGATURES AND SAFE USE OF LIGATURE CUTTERS (Proc447)

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Chair of approving group	*Sarah Smyth, Executive Director of Nursing, Allied Health and Social Care Professional*
Name of approving group:	*Physical Health and Medical Devices Group* *Quality Patient and Safety Group*
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Next Full Review date:	*September 2028*

Document control – changes record.

Version	Date	Change details (type of change – minor/signficant and full or interim review)
1.0	*April 16*	*New procedure*
1.1	*April 16*	*Amended following consultation*
2.0	*Oct 16*	*Revision to procedure to include new guidance for reporting ligature use on Datix*
2.1	*Oct 18*	*Minor changes to references*
2.2	*Oct 18*	*Review of procedure when recording incidents on Datix following consultation with CRMG*
2.3	*April 22*	*Review and minor amendments to procedure. Aligned with divisional roles and repsonibilties, removed care groups. Updated references. Changes to audit and monitoring and addition of requirments on induction. Addition of Escalation Pathway Following a Ligature.* *Approved at PHMD 28-Apr-22*
2.4	*Sept 25*	*Full review with minor amendments to include* *- revision of procedure to include new guidance and reference of NICE and CQC self harm and ligature guidance.* *Approved at QPaS (19 September 2025).*

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1. Introduction

Deaths by hanging (which includes suspension from anchor points and self-strangulation without suspension) accounted for 61% of all suicides in England in those aged 10 years and above (Apr-Jul 2020) (Office for national statistics, 2021). A rapid and effective response to remove a ligature can reduce harm (both immediate and long term) to the person.

2. Scope

This procedure is aimed at all substantive clinical staff who work in the patient areas identified below and is irrespective of role or banding.

Students and agency staff in the clinical teams are expected to know the whereabouts of the ligature cutter in the relevant ward/team base and be able to collect this in the event of a ligature occurring, however would not be expected to remove the ligature unless training has taken place.

Risk areas in scope are defined as: All inpatient services for mental health and learning disability including adult mental health, older people, learning disability, secure forensic services, CAMHS and the crisis teams where assessment rooms are provided on site and a ligature anchor point audit is undertaken

3. Duties and Responsibilities

Staff group	Duties
Director of Nursing, Allied Health and Social Care Professionals	The Director of Nursing, Allied Health and Social Care Professionals has overall responsibility for ensuring that the Trust has in place a clear procedure for clinical staff to respond to the discovery of a patient with a ligature, that appropriate arrangements are in place to enable safe and effective care and that employees are fully aware of their statutory, organisational and professional responsibilities and that these are fulfilled.
General Managers and Divisional Clinical Leads	General Managers and Divisional Clinical Leads are responsible for ensuring that appropriate actions have been taken to enact the requirements of this procedure within their Divisions. Specifically that they have identified those high risk teams and services to which this procedure applies and that they receive assurance from the services that there are no barriers to this procedure being enacted.
Matrons/Senior Clinical Leads and Unit/Team Managers of risk areas in scope	Matrons and Unit/team managers are responsible for ensuring that: • High risk teams/services are aware that they need to comply with this procedure • Each team has a minimum of 2 ligature cutter and is aware of the procedure for replacement • That the agreed ligature cutter is procured for identified teams/services. • That the location of the ligature cutter is known to all substantive clinical staff and that where possible this is consistent across the division • All designated clinical staff in the team have received training on use of the ligature cutter and maintain training records locally.

	• All designated clinical staff have received life support training in line with the statutory/mandatory training requirements (ILS/BLS) • To reinforce to staff the need to complete a Datix when a ligature cutter is used in practice • To ensure that blades are replaced as per procedure and records kept for scrutiny within local risk management file.
Resuscitation Officer/trainers	To teach rescue from neck ligature on all ILS & BLS courses within the Trust.
Registered Nurses in high-risk areas	• To be familiar with this policy and attend ILS (RC UK) annually • To be familiar with the ligature cutters used within HTFT • To ensure records of using a ligature cutter are completed on DATIX • To replace the blade/knife in line with procedure and inform the unit manager.
All Staff	The Trust expects all staff to contribute to its determination to provide safe care and, in doing so, to uphold the statutory Duty of Candour and to meet the responsibilities articulated in their professional standards and in NHS and Trust Values. All staff should ensure that they are familiar with the requirements of the legal Duty of Candour, as set out in the Trust's Duty of Candour Policy and Procedure

4. Procedure Main Body:

All patients accessing Humber Teaching NHS Foundation Trust Mental health services will have a comprehensive risk assessment carried out in line with Procedure.

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4.1. Risk Assessment and provision of ligature cutters

1. All high-risk clinical teams (as above) are required to procure and maintain ligature cutters in line with this procedure.
2. If a clinical team not identified in the high-risk areas above assess themselves as requiring ligature cutters, they should inform their Matron or Divisional Clinical Lead and follow this procedure accordingly.
3. The agreed ligature cutters for use in HTFT are the Shark Knife and Ligature Scissors

4. A **minimum** of 2 shark knives **and** 2 pairs of ligature scissors should be kept by each team/service to ensure a cutter/scissors is always available and fit for purpose.

4.2. Storage of ligature cutters

In each clinical area where provision of ligature cutters is indicated, resuscitation equipment will also be provided. It is considered best practice to co-locate the ligature cutters with the resuscitation equipment. This will ensure that all clinical staff who may move areas or support other units do not confuse the location of the ligature cutters

Induction for substantive and temporary clinical staff must include the location of the resuscitation equipment with specific reference to the co-location of the ligature cutter.

Additional ligature cutters should be stored, as agreed locally with the team/service manager in a location that is not accessible to patients but can be accessed by staff in the event of a replacement being required at any point over 24hours. Team managers should ensure the location is included as part of the local induction to the unit. Signage may be appropriate and can be used at the discretion of the unit manager.

Ligature cutters must not be moved from designated locations without ensuring all staff in the department are aware. Cutters must never be removed from the resuscitation trolley / bag, except for use, and shark knives must have a new blade inserted immediately after use.

Daily ward / department checks must include ensuring that additional cutters are located in the identified place.

4.3. Cleaning/Sharpening of Ligature Cutters

The ligature cutter is classed as a multiple patient use device and as such must be decontaminated between uses.

As a critical safety item, relying on its sharpness to save life, ligature cutters need to be sharp for every use.

Shark Knife

After use the Shark knife should be cleaned with 70% Isopropyl alcohol wipes x 2 (or detergent and wipes). The Shark knife should then be returned to its appropriate storage location. The blade will need to be replaced as appropriate. If there is any doubt regarding the previous use of a ligature cutter the blade should be replaced. The old blades should be disposed of in line with the safe sharp's procedure.

Ligature Scissors

Should be cleaned as per the Shark knife above

Ligature scissors should be replaced every 2 months as a minimum **unless** the ward manager is confident that they have not been used for any purpose. This can be checked by reviewing the usage sheet for those specific scissors as well as the Shark knife on a weekly basis. The ward manager is responsible for setting up a system that ensures they are replaced every 2 months (or if they have been used excessively in a month the ward manager will note use from Datix and request earlier replacement).

If there is any doubt about the frequency of use of the ligature scissors they should be replaced.

To allow for monitoring of use of the ligature cutters after each use this must be recorded on the monitoring form (Appendix 1). This will be checked by the ward manager weekly to ensure this aspect of the procedure has been implemented.

4.4. Managing the removal of the ligature

Any substantive or clinical staff on temporary bank contracts who have received training, either on the ward or via ILS/BLS training, may be required to use a ligature cutter in an emergency. It is essential that all clinical staff, working in areas where ligature cutters are provided are trained and feel confident in using them. It is a staff members personal responsibility to highlight to the nurse in charge if they do not feel confident in using these items.

Staff should be aware of the location of the incident, as well as other patients and

visitors who could present a risk. Staff should ascertain whether the ligature itself may present a risk e.g. pressurised lines and live electrical cables may be used to hinder rescue. Where possible, staff must avoid cutting the knot, as this makes removal more difficult and it may be required later for forensic investigation.

Strangled Casualty

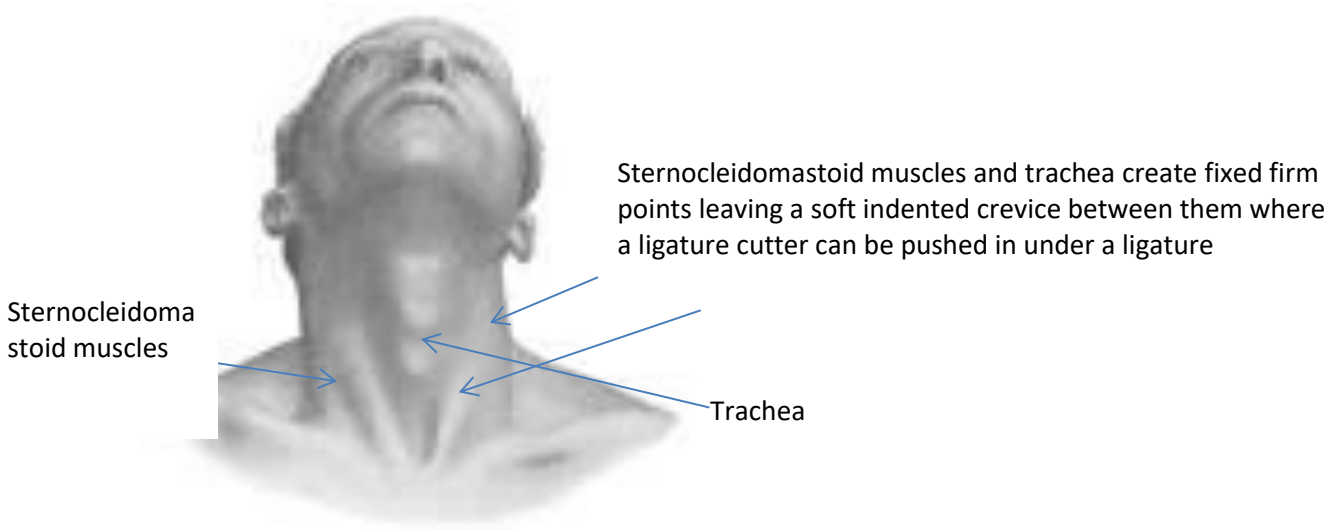
All casualties of strangulation should be treated as a suspected neck injury

Upon finding a casualty as described follow the guidelines below:

- Shout for assistance, activate alarms and ensure a safe approach to the casualty for yourself and other rescuers.
- Where the casualty is suspended from a high anchor point:
    - Approach from the front if possible; take care not to injure yourself or colleagues
    - With your knees bent encircle your arms around the casualty and then carefully straighten your knees to reduce the weight and tension of the casualty against the ligature. When possible use two or more staff. If 2 rescuers are present both do this simultaneously to share some of the weight.
- Where the casualty is kneeling, semi seated or lying, attempt to support the person to relieve as much pressure as possible whilst the ligature is cut away
- As soon as is possible support the casualty's head in alignment with their shoulders
- Once the ligature cutter arrives cut the ligature through the thinnest part that is NOT around the neck to release the casualty from being suspended/attached to the anchor point. Lower the casualty to the ground very carefully and maintain head and shoulder alignment as much as possible throughout the cutting down and cutting off the ligature. Put the casualty in to a supine position and maintain the head neck shoulders and torso in alignment.

When the casualty is no longer suspended or has been found not suspended then:

- Use ligature cutter soft edge to push into the soft tissue between the trachea and Sternocleidomastoid muscle on the neck.



- Hook the cutter under the ligature so as to position the ligature inside the curve of the blade.
- Cut the ligature whilst pulling the ligature away from the neck until the ligature is cut through

ONCE THE LIGATURE IS REMOVED CHECK THE PATIENT FOR A RESPONSE

- Gently shake the casualty's shoulders and ask, 'Are you all right?'

<table>
<tr><td rowspan="3">IF THEY RESPOND

Try to keep manual in line stabilisation (Head & shoulders in alignment)

Explain to the casualty what you are doing and that it is important that they cooperate.

If the casualty is uncooperative do not force them to remain still, simply let them go.

Use the ABCDE approach to assess & reassess.

Deterioration may occur.

Watch for difficulties developing such as changes in conscious level, difficulties with swallowing or breathing</td><td colspan="3">IF THEY DO NOT RESPOND

Take no more than 10 seconds to determine if the casualty is breathing normally and / or has a carotid pulse</td></tr>
<tr><td>If the casualty is breathing normally and has a carotid pulse the casualty is Unconscious

Maintain a patent airway

Give oxygen via a non-rebreathing mask at 15 litres per minute

Assess the casualty using the ABCDE approach</td><td>If the casualty is not breathing normally but has a carotid pulse the casualty is in Respiratory arrest.

Using a pocket mask or bag-mask device ventilate the patient and check for a pulse every 10 breaths (1 minute)

At any stage if a carotid pulse cannot be felt or there is doubt change to full Cardiopulmonary Resuscitation (CPR)</td><td>If the casualty is not breathing and a carotid pulse cannot be felt the casualty is in Cardio-respiratory arrest

Initiate CPR immediately

Use a cycle of 30 compressions to 2 breaths and attach an Automated External Defibrillator (AED) as soon as possible.</td></tr>
<tr><td colspan="3">If available use an i-gel (supraglottic airway) to secure a patent airway
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Following a hanging / asphyxiation care needs to be taken to avoid aggravating a cervical spine injury.

A patent airway should be maintained by use of a jaw thrust or chin lift whilst manual in line stabilisation of the head and neck are maintained by an assistant.

If the above does not keep an airway patent add a degree of head tilt until patency is achieved. Airway patency must take priority over any concerns about a cervical spine injury.</td></tr>
</table>

Reference: Immediate Life Support Manual 5th Edition January 2022 Resuscitation Council (UK)

- Continue to assess and reassess A-E as per ILS guidelines treating findings wherever possible, difficulties with breathing, swallowing, changes in conscious level, agitation, confusion that may develop when not evident initially.
- Ensure a medical review takes place as soon as possible. If the patient does not attend A&E this must be assessed and confirmed by the attending medic
- An initial NEWS2 must be completed to monitor for any signs of deterioration in the patient's condition. If clinically indicated this must then be completed every 15 minutes for the first hour or until the patient has been medically reviewed. If the patient requires transfer/admission to the acute trust, then guidance regarding physical observations on the patient's return should be given by the on-call doctor.

- If any form of BLS/ILS is carried out, then the Resuscitation Outcome Report form should be completed as per HTFT Resuscitation and Medical Emergencies Policy M–004.

4.5. Patients who are not co-operative with ligature removal from the neck

Where a patient has a ligature to the neck the clinical team is required to make a decision about interventions to manage the situation immediately.

Restraining a patient whilst removing a ligature can present with risks, it is therefore essential that the clinician removing the ligature is trained with the safe use of the ligature cutter. Restraint must take place in line with the approved DMI training and holding of the head and neck must not be attempted to remove a ligature.

Where the patient is still conscious clinical staff should assess the situation and **risks** of approaching the patient to remove the ligature. If a threat of weapon use is imminent, clinicians should make a clear risk assessment and document this as soon as possible; specifically, where removal of the ligature has not been possible at the time of discovery. The appropriate support should be sought to manage the situation in relation to threat of weapons or environment.

If the patient is not co-operating but does not present with a weapon or other high risk to prevent staff intervention, the clinical team should quickly agree an intervention plan, which may include the use of restraint to enable the safe removal of the ligature from the patient. This decision should be made in conjunction with Senior Colleagues if available at the time, but intervention should not be delayed if this would pose a risk to patient safety.

If the patient is not going to co-operate with removal under restraint, the risk of damage to head and neck and/or damage to the neck area in using the ligature cutter will constitute an equal if not more serious risk of harm to the patient**. The attempt to remove the ligature should be ceased immediately**. Documentation post incident is essential to clinically validate the rationale for non-removal of a neck ligature.

Given the physical stress that arises in the patient during restraint it is essential that a member of staff who is ILS trained is monitoring the patient's physical wellbeing, using NEWS2, during the restraint and leading up to removal of ligature.

If following a risk assessment it is felt that to attempt to use the cutter under restraint will/has increased the risks of injury to the patient and staff then the following steps should be taken:

1. A Senior Clinician is designated to lead the intervention and delegate the below responsibilities to colleagues, as appropriate.

2. A clinician is assigned to verbally de-escalate the situation with the patient. Only one clinician should talk to the patient during this period to reduce stimulation and allow for talk down; attempting to negotiate removal of the ligature before consciousness is lost.
3. A 2nd clinician is assigned to monitor the patient's physical wellbeing and gives the call to immediately intervene if it appears that the patient is going to lose or loses consciousness. Resuscitation equipment should be on standby.
4. A medic should be called to attend the situation for monitoring post removal, though in the event of an emergency arising, an ambulance may be the priority. Removal of the ligature should not wait for the arrival of a medic.
5. Actions as previously described to remove the ligature Section 5.4
6. Immediately assess and treat the casualties ABCDE. Call for an emergency ambulance if the casualty is not responding to voice or immediately alert after ligature removal
7. Follow Resuscitation Council UK current guidelines if the casualty is in cardiac arrest**.**

Document all interventions and interactions made throughout the episode of care provided. Complete **Datix** for the incident and Resuscitation Outcome Report form and a separate Datix if restraint was used.

4.6. Post Ligature Removal

Following removal of a ligature the patient must be reviewed by a doctor as clinically indicated, dependent upon the severity of the attempt. If a doctor is not called, the rationale must be clearly articulated in the clinical notes. Please use the below as guidance when considering escalation to the acute hospital and further medical treatment/intervention as well as Appendix 2, Escalation Pathway Following a Ligature

RED – Immediate 999 transfer to the Acute Trust for ANY of the following:

- **Where resuscitation was required.**
- **Where there is suspicion of neck injury.**
- **Difficulty swallowing, & or painful swallowing.**
- **Suffocation when sticking out the tongue.**
- **Tenderness over the Larynx.**
- **Other symptoms such as crepitus (crackling heard on stethoscope auscultation), dyspnoea (persistent breathlessness), dysphonia (hoarseness), and subcutaneous crepitus (air under skin with crackling/crunchy feeling to touch).**
- **Any loss of consciousness or suspicion of loss of consciousness.**
- **Deeply indented ligature mark.**
- **A long period of ligature. This increases the risk of venous compromise & increases risk of delayed complications.**
- **Cyanosis not subsiding immediately after ligature removal.**
- **Continued sweating/clamminess.**
- **Continued coughing.**
- **Petechial haemorrhages (small red marks with pinpoint centres on eyes, face, neck or lips which are broken blood vessels indicating that asphyxiation has taken place).**

AMBER

Any other concern not outlined in the RED criteria or NEWS2 score above baseline:

- **Discussion with Ward based Doctor or Out of Hours Duty Doctor**
- **Observations to be conducted every 15 mins for first 90 mins, timings can then be reviewed after discussion with the doctor.**

GREEN

Patient at baseline:

- **NEWS2 score at baseline for 90 minutes post incident**
- **Continue to monitor for next 36 hrs for signs of deterioration**
- **Any concerns re patients' physical health escalate to ward doctor**

Staff must retain the cut ligature for later inspection. In the event of injury to the patient, or fatality the ligature will form part of the investigation. Where part of the ligature remains attached to a ligature point, it should not be removed until this has been authorised by the police or appropriate senior staff.

In the event of a fatality, the room and all of its contents must not be touched or moved and the room secured to prevent anyone accessing it until the police have arrived. The ligature must be left in the room.

If there are any injuries relating to the cutter being used, these must be recorded on Datix. Staff injuries must also be highlighted to the manager in charge, patient injuries must be recorded in their clinical notes.

All relevant documentation relating to a serious untoward incident must be completed.

Post Incident Review:
Staff should be offered a Post Incident Review in line with current Trust guidance.
The patient and any other involved individuals should also be offered the opportunity to discuss the incident and how it was managed.

Documentation
An accurate record of events relating to the use of the ligature must be recorded in the clinical records, where possible with accurate date stamps to indicate timings of interventions. Staff names and other witnesses must be recorded in the clinical record.

4.7. Reporting of Ligature use by Datix

The following guidance is to support staff in the use of DATIX to report ligatures tied to the neck by patients:

1. Ligatures tied using an anchor point on any Trust premises must be reported immediately through DATIX. The unit manager or line manager must also be informed. Immediate actions must be taken to reduce the risk whilst a full clinical assessment takes place.
2. Ligatures tied that cause the patient to appear physically in distress (includes change in pallor and breathing) must be individually reported on DATIX, where urgent medical intervention has been required (999) an initial incident review (IIR) may be requested via the corporate safety huddle. The Safeguarding box on datix should be ticked.
3. Ligature tied by a patient where a management plan is not in place (see below) must be reported on DATIX or where the nature/circumstances of the ligature fall outside the remit of the management plan an initial incident review (IIR) may be requested via the corporate safety huddle. The Safeguarding box on datix should be ticked.
4. Ligatures monitored and managed through an Individual Clinical Safety Plan. Some patients use ligatures as a means of managing and expressing their distress on a regular basis. Where a patient uses ligatures and this is a recognised behaviour, the clinical team may develop an individual person centred safety plan to work with the patient. All instances will be recorded on a separate Datix.

Best practice in the management of patients who regularly self-ligate and where an individual clinical safety plan has been put in place to manage this clinical presentation MUST include:

- Patient involvement to create person centred safety planning
- Family or carer involvement, with the patient's permission to support the agreed clinical management/safety plan

- A minimum of 3 professionals in agreement with the clinical safety plan
- Regular external review of the clinical management plan, to be agreed no less than 4 weekly with a member of the safeguarding team and an independent professionally registered clinician from another unit/service. This will ensure external scrutiny outside the ward.

5. Training

5.1. Induction Training

On induction to the ward the procedure and practical skills required to use the ligature cutter for substantive staff joining the clinical teams in those high-risk areas where ligature cutters are in use will take place and be recorded as part of the induction.

5.2. Statutory/Mandatory Training

Training in the use of ligature cutters comprises a demonstration to all relevant staff (those working in areas where ligature cutters are provided) during mandatory BLS and ILS courses. This includes temporary and bank staff.

5.3. Clinical Training

Further training regarding the use of ligature removal equipment is available divisionally and can be accessed through Healthcare Development Training and Preceptorship packages.

6. Dissemination and Implementation

This procedure will be discussed with the Matrons/Senior Clinical Leads/ Team Managers for those services and wards that are identified as high-risk areas and will be provided with ligature cutters in Humber Teaching NHS Foundation Trust.

Through the management structure, staff will be provided with introductory training session to ensure the successful implementation of this procedure, which includes knowledge of the procedure and practical skills in using the cutters.
All Team Managers will need to keep copies of inductions for new starters for audit purposes. Thereafter the ILS/BLS courses for high-risk teams will include scenarios on use of the ligature cutters.

Temporary and agency staff will be made aware on induction of the location of the ligature cutter and resuscitation equipment in order to provide a rapid response. Where an agency nurse is to take charge of a team or ward, the registered nurse handing over is responsible for ensuring that a minimum of one member of staff is substantive and is aware on how to use the ligature cutter.

In the extreme circumstances where a review of the staff left on duty indicates none have been trained in the use of the ligature cutter and resuscitation equipment, the nurse in charge must escalate the issue to a senior manager who will advise on appropriate actions.

This procedure will be disseminated by the method described in the Document Control Policy

7. Monitoring, Auditing and Compliance

- The Matrons/Senior Clinical Leads and Unit Leadership are responsible for ensuring that the induction processes (for areas that require a ligature cutter) includes a training session on the procedure and practical skills to use a ligature cutter
- As part of the monthly Matron Audit completed inductions will be reviewed to ensure compliance with this Procedure. Records will be held locally by the unit/team leadership.

8. References / Related Trust Documents

- Resuscitation Council UK 2021 Guidelines
- Office for national statistics (ONS) (2021) Deaths from suicide that occurred in England and Wales: April to July 2020
- Joint Royal Colleges Ambulance Liaison Committee Guidelines 2022 (JRCALC)
- Acknowledgement of procedures on use of ligature cutters from Nottinghamshire NHS FT and Leeds & York NHS FT
- HSE. *Manual Handling Operations Regulations* 1992. HMSO.
- Acknowledgment of use of Clinical Protocol Ligature and Near Hanging Devon Partnership NHS Trust 2020.
- CQC. Reducing harm from ligatures in mental health wards and wards for people with a learning disability. 2023.
- NICE. Self-harm: assessment, management and preventing recurrence. 2022.
- Medical Emergencies and Resuscitation Policy and procedure (M-004)
- Moving & Handling Policy (HR-025)
- Management of Violence and Aggressive Behaviour (N-049)
- The Use of Seclusion or long-term segregation including restrictive Intervention Procedure (M-008)

Appendix 1 – Ligature Cutter Use Audit Form

Ward:----------

Date Ligature Cutter Used	Which Ligature Cutter was used? Scissors/Shark Knife	Type of Ligature Removed: (i.e., Shoelace, Clothing etc.)	Blade/Scissors Replaced Y/N	Staff completing the Log Signature	Charge Nurse Weekly Check Signature

Appendix 2 – Escalation Pathway Following a Ligature

Appendix 3 – Equality and Health Inequalities Impact Assessment (EHIIA) Toolkit

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document of Process or Service Name: Procedure for the Safe Use of Ligature Cutters
2. EHIIA Reviewer (name, job title, base and contact details): Dani Wilkinson – Senior Clinical Lead
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? Policy

Main Aims of the Document, Process or Service
To set out the requirements that must be met for approval, ratification and dissemination of all Humber Teaching NHS FT policies.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the proforma

Equality Target Groups	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed? Equality Impact Score Positive = evidence of positive impact Neutral = little or no evidence of concern (Green) Moderate negative = some evidence of concern (Amber) High negative = significant evidence of concern (Red)	How have you arrived at the equality impact score? • who have you consulted with? • what have they said? • what information or data have you used? • where are the gaps in your analysis? • how will your document/process or service promote equality and diversity good practice?
This toolkit asks services to consider the impact on people with protected characteristics under the Equality Act 2010 as well as the impact on additional groups who may be at risk of experiencing inequalities in access, outcomes and experiences of health and care.		

Equality Target Group	Definitions (Source: Equality and Human Rights Commission, 2024)	Equality Impact Score	Evidence to support Equality Impact Score
Age	A person belonging to a particular age (for example 32-year-olds) or range of ages (for example 18- to 30-year-olds).	Neutral	See summary.
Disability	A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.	Neutral	See summary.
Sex	Man/Male, Woman/Female.	Neutral	See summary.
Marriage/Civil Partnership	Marriage is a union between a man and a woman or between a same-sex couple. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must not be treated less favourably than married couples.	Neutral	See summary.
Pregnancy/Maternity	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a person unfavourably because they are breastfeeding.	Neutral	See summary.

Race	A race is a group of people defined by their colour, nationality (including citizenship) ethnicity or national origins. A racial group can be made up of more than one distinct racial group, such as Black British.	Neutral	See summary.
Religion or Belief	Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief and includes a lack of belief. Generally, a belief should affect your life choices or the way you live for it to be included in the definition.	Neutral	See summary.
Sexual Orientation	Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.	Neutral	See summary.
Gender Re-assignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Neutral	See summary.
Poverty	People on welfare benefits, unemployed/low-income, fuel poverty, migrants with no recourse to public funds	Neutral	See summary.
Literacy	Low literacy levels, including includes poor understanding of health and health services (health literacy) as well as poor written language skills	Neutral	See summary.
People with English as an additional language	People who may have limited understanding and/or ability to communicate in written or spoken English	Neutral	See summary.
Digital exclusion	People who can't or don't want to use digital technology due to cost, access to connectivity or devices, digital skills or lack of confidence or trust in digital systems	Neutral	See summary.
Inclusion health groups	People who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes:	Neutral	See summary.
	• people who experience homelessness	Neutral	See summary.
	• drug and alcohol dependence	Neutral	See summary.
	• vulnerable migrants	Neutral	See summary.
	• Gypsy, Roma and Traveller communities	Neutral	See summary.
	• sex workers	Neutral	See summary.
	• people in contact with the justice system	Neutral	See summary.
	• victims of modern slavery	Neutral	See summary.
Rurality	People who live in remote or rural locations who may have poor access to services.	Neutral	See summary.
Coastal communities	People who live in coastal communities which may experience unemployment, low educational attainment, poor social mobility, poor health outcomes and poorer access to services.	Neutral	See summary.
Carers	Carers and families of patients and service users, including unpaid carers and paid carers	Neutral	See summary.
Looked after children	A child or young person who is being cared for by their local authority. They might be living in a children's home, or with foster parents, or in some other family arrangement.	Neutral	See summary.

Veterans	Anyone who has served for at least one day in Her Majesty's Armed Forces (Regular or Reserve) or Merchant Mariners who have seen duty on legally defined military operations.	Neutral	See summary.
Neurodivergence	People with alternative thinking styles such as autism, attention deficit hyperactivity disorder, dyslexia, developmental co-ordination disorder (dyspraxia), dyscalculia.	Neutral	See summary.
Other	Any other groups not specified in this toolkit who may be positively or negatively impacted	Neutral	See summary.

Summary

Please describe the main points/actions arising from your assessment that supports your decision above No impact to the protected characteristics and health inequalities have been identified in this policy.	
EIA Reviewer: Dani Wilkinson	
Date Completed: 14.09.25	Signature: D.Wilkinson