Reporting to:	**Trust Board - 30 June 2016**
Title	2015-16 Annual Security Report
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Previously considered by	H&S Committee (4 July 2016 (previously scheduled for 14 June 2016) Audit Committee (2 June 2016) Julia Clarke, Director Corporate Governance (5 May 2016) Violet Redmond, Head of Legals & Security (26 April 2016)
Executive Summary	The NHS Standard Contract published by NHS England is used by CCG's when commissioning NHS Services. Security management conditions are set out in the general conditions section and place obligations on providers including maintaining security management arrangements, for commissioners to review the security management provisions put in place by the provider and for the provider to implement any modifications required by the commissioner. This report is one of a number of methods by which the Trust evidences security management activities to the Trust Board, NHS Protect and others and highlights security management at SaTH; of note during 2015-16: • The number of reported incidents of intentional violence and aggression is showing a generally decreasing number of incidents. • Work to gain some form of sanction or redress for acts of intentional violence and aggression including verbal abuse remains strong with joint working with police and the use of our existing framework for the issue of written warnings. • The number of non-intentional (clinical) aggression incidents resulting in physical contact and/or injury/harm to staff has decreased and is benefitting from a new policy and strategy for dealing with clinically aggressive patients along with more appropriate training for staff in managing clinically challenging behaviour and prioritisation of conflict resolution training for most effected staff groups as well as specialist training provided by our partners at South Staffordshire & Shropshire Mental Health Trust for our security teams.
Strategic Priorities ☒ People and Innovation ☒ Community & Partnership	**Operational Objectives** PI1 Implement a Staff Engagement Framework that improves employment experience and reduces absence to less than 4% CP1 Develop an integrated service strategy in conjunction with all health and social care partners CP6 Achieve sustained improvement in trust, confidence, reputation, customer service and public/community engagement

Board Assurance Framework (BAF) Risks	☒ Deliver Safe Care or patients may suffer avoidable harm and poor clinical outcomes and experience. ☒ Achieve safe and efficient Patient Flow or we will fail the national quality and performance standards. ☒ Good levels of Staff Engagement to get a culture of continuous improvement or staff morale and patient outcomes may not improve.
Care Quality Commission (CQC) Domains ☒ Safe ☒ Effective	**Outcomes** *7: Safeguarding people who use services from abuse - People should be protected from abuse and staff should respect their human rights.* *10: Safety and suitability of premises - People should be cared for in safe and accessible surroundings that support their health and welfare.* *12: Requirements relating to workers - People should be cared for by staff who are properly qualified and able to do their job.*
☐ **Receive** ☐ **Review** ☒ **Note** ☒ **Approve**	**Recommendation** The Board is asked to note the reported activity and information and approve the report.

The Shrewsbury and Telford Hospital NHS
NHS Trust

Annual Security Report

2015-16

Foreword

The Shrewsbury and Telford Hospital NHS Trust remains committed to the delivery of a secure environment for those who use or work in the Trust so that the highest possible standard of care can be delivered; to this end security remains a key priority within the development and delivery of health services. All of those working within the Trust have a responsibility to assist in preventing security related incidents or losses. This approach underpins and directly links to the Trust's values and objectives.

Julia Clarke (Director of Corporate Governance) is the designated Board level lead Executive Director for security management matters, including tackling violence against NHS staff and must ensure that adequate security management is made at the Trust.

Robin Hooper is the Non-Executive Director whose responsibility is to promote and champion security management at Board level.

Violet Redmond is Head of the Trust's Legal and Security Services Team.

Jon Simpson is the Trust Security Manager and NHS accredited Local Security Management Specialist (LSMS) who ensures that the Trust complies with all NHS security guidance and requirements and also oversees the implementation of security management across the Trust.

During the reporting period, there has been further progress with efforts to reduce levels of violence and aggression towards staff from service users, coupled with development in security services, which are detailed in this report and reflect the Trust's commitment to deliver a safe and secure environment.

1 June 2016

Julia Clarke

Director Corporate Governance

Robin Hooper

Non-Executive Director

Introduction

This report summarises the work undertaken in the last year towards ensuring a safe environment for staff and patients protecting property and assets. The Board is clear that the starting point for sound security arrangements is to provide clear goals and a business process and framework for all staff. This is reflected within this report by efforts towards policy development and risk assessment, partnership working with police and NHS Protect and internal efforts, whether this is between medical/nursing staff teams with our security response teams or security management support and influence with Estate and Centre Management teams. All this supports and underpins incident reporting to protect our staff, patients, visitors and assets. All of this is underpinned by training to raise awareness and ensure that the Trust is a safe place for all.

Julia Clarke (Director of Corporate Governance) is the nominated director with responsibility for security management and ensures that security issues are considered at the highest level and where necessary, brought to the attention of the Board. The Non-Executive Director champion for security management is Robin Hooper.

Violet Redmond is Head of the Trust's Legal and Security Services Team. Day to day security management is undertaken by Jon Simpson, the Trust Security Manager and accredited Local Security Management Specialist (LSMS). He is directly responsible for translating national guidance, policies and initiatives into good practice locally and works closely with staff at all levels on a range of matters including; security risk advice, improvements to security infrastructure and procedure, undertaking incident investigation and supporting staff who have been victim to adverse incident. In addition, he acts as liaison to supporting partner agencies undertaking criminal proceedings on behalf of the Trust.

1 Governance

A sound Governance framework is essential in ensuring a consistent approach to security issues across the Trust.

1.1 *Standards for Providers*

Under the provisions of the NHS Standard Contract, Providers are required to have in place and maintain security management arrangements in their organisations. Commissioners are required to review these arrangements to ensure the Provider implements any modifications required by the Commissioner. As part of the process to collate evidence of security management activity (aside from publishing this Annual Report), the Trust also submits an an evidenced based Self Risk Assessment (SRA) set against 30 national security standards, to NHS Protect. Work is now underway to prepare our 2016-17 submission, based on results and outcomes from 2015-16.

1.2 *Policy*

The following security policies were reviewed during the reporting period.

- Closed Circuit Television (CCTV) (December 2015);
- Lock Down (December 2015);
- Counter Terrorism procedures (December 2015);
- Violence & Aggression (November 2015).

A new security policy concerning the 'Hosting of prisoners on Trust premises' was published in November 2015.

Advice and input in relation to security management and counter fraud matters was provided for a new Trust policy concerning Asset Disposal.

Prior to publication, new and/or updated policies are first approved by our Policy Approval Group (PAG). This is a multidisciplinary group chaired by the Director of Corporate Governance that ensures all new and reviewed policies are compliant with Trust standards and that appropriate consultation has been undertaken before recommending them for ratification with the Senior Leadership Team (SLT).

1.3 *Security Risks*

All security risks are managed in accordance with the Trust Risk Policy. All risks which have been scored and evaluated as requiring to be placed on a department or Clinical/Corporate Centre register or the Trust Risk register, are entered on to the 4Risk system where they, and accompanying action plans, are regularly reviewed. The requirement to regularly review and record progress is initiated by a system generated electronic alert to the risk owner; oversight

of this process is undertaken by the Head of Assurance and reported to the Operational Risk Group (ORG). There are currently no recorded security risks scoring 15 or more.

1.4 *Preventative Security Risk Assessment*

Preventative security risk assessment is undertaken by the Trust Security Manager and department management teams. Following an assessment, quick fix local action plans can be agreed which can be implemented by management teams with security management support where appropriate. This process complies with Service Condition 24 of the NHS Standard Contract. In the reporting period assessments were completed on a number of areas at both sites including:

- RSH (Copthorne Building) Medical Engineering Department: Due to increased vulnerability outside of core hours following the transfer of Women & Children's (W&C) Services to the Shropshire W&C building at the PRH.
- PRH A&E Department: To identify additional security infrastructure in support of planned alterations in the department.
- PRH Shropshire W&C Centre: Concerning the reconfiguration of access control systems in the Walker Suite /seminar room areas and Neonatal Ward.
- RSH & PRH Theatre complexes: Concerning target hardening[1] by way of additional CCTV and more secure storage following counter fraud concerns over stock control.
- RSH SAU: Concerning access control arrangements to medical offices from public reception area.
- RSH General Stores: Following concern regarding fraud and stock control from unplanned/unauthorised access to the department outside of core working hours.
- PRH Pharmacy: Concerning better use of existing CCTV and access control arrangements to address a number of vulnerabilities identified by department management.
- RSH Block 2, 3 & 4: To provide guidance and options concerning partially redundant/former staff accommodation/offices.

Existing security risk assessment for Radiography departments at both sites, the RSH A&E and Ward 10 at the PRH were also reviewed and updated/re-issued. In addition a full security specification was developed and advice given to support the RSH Mortuary re-build.

1.5 *Committee Work*

The Trust Security Manager attends all Health, Safety & Security Committee meetings. This committee, chaired by the Director of Corporate Governance, meets quarterly, and fulfils the Trust's requirement to have a Security Committee. Security is embedded as a standing item in

[1] Target hardening, also referred to simply as hardening when made clear by the context, is a term used by police officers, those working in security, and the military referring to the strengthening of the security of a building or installation in order to protect it in the event of attack or reduce the risk of theft.

each agenda and a quarterly security report is presented by the Trust Security Manager and discussed at each meeting. In the fourth quarter, the annual security report is presented.

The Trust Security Manager attends all Operational Risk Group (ORG) meetings, co-chaired by the Director of Corporate Governance and the Head of Assurance, and this ensures security management oversight and advice is readily available for all matters discussed or raised.

1.6 *Release of Information, Freedom of Information (FOI), Complaints & Challenges*

No releases of CCTV video footage were made to the public during the reporting period. The Trust provided CCTV and/or video footage from Body Worn Video camera equipment to West Mercia & Warwickshire Police on 18 occasions. These releases concerned all manner of criminal and/or suspicious activity that occurred on Trust premises. Although some of the releases concerned incidents which did not occur on Trust premises, it was often the case that the original incident subsequently led to other adverse attendance or activity on Trust premises. 3 releases were made to the Patient Safety Team to assist with Root Cause Analysis (RCA) patient safety investigations. 4 releases were made to Managers and/or Human Resources (HR) to assist with fact finding/HR investigations.

8 FOI requests were made regarding security matters and reported incidents at the Trust. Available information was passed to the Trust Communications Team for onwards transmission.

During the reporting period 1 formal complaint was received by the Trust from a member of the public alleging a breach of her confidentiality by security staff. The matter was subsequently closed with no case to answer and passed back to the Complaints Team for final response.

During the reporting period a patient awaiting observations claimed to have observed a member of the PRH security team roughly man-handling an elderly male patient and communicated her concern to the Trust's Safeguarding Team. On investigation CCTV evidence showed no case to answer on the part of the Security Officer concerned. The concerned patient was contacted by Safeguarding Team and the matter discussed/closed.

A complaint from staff in the RSH A&E department regarding observed unauthorised access by car park attendant staff to the RSH CCTV security camera control room resulted in verbal warnings to concerned staff by their parent company management team.

During the reporting period 3 members of the public previously sent warning letters regarding their behaviour, either when in contact with or on Trust premises, challenged the version of events given by staff reporting the original incident. However, after independent review of one incident by the Head of Assurance, the individual failed to or was unable to clarify what their concern was. In the other two instances, a review by the Trust's Legal & Compliance Manager found no case to answer in either case as regards the decision to send the letter. Explanation letters were sent in both cases with no further interest noted/received from those concerned.

2 Security Incident Reporting

Security incident reporting remains key to the maintenance of a pro-security culture. Figures below demonstrate good awareness by staff on how to report and the need for doing so.

2.1 Comparative figures for 2015-16 are shown in Table 1[2].

Table 1 - Security Incident Reporting

ALL SECURITY INCIDENTS	2013/14	2014/15	2015/16
First quarter: Apr, May, Jun	188	133	143
Second quarter: Jul, Aug, Sep	143	147	153
Third quarter: Oct, Nov, Dec	162	118	197
Fourth quarter: Jan, Feb, Mar	186	169	182
Running Total	**679**	**567**	**675**

2.2 Of the reported 675 incidents in 2015-16, 370 occurred at the Royal Shrewsbury Hospital (RSH), 303 occurred at Princess Royal Hospital (PRH) and 2 occurred at other healthcare premises, but involved Trust staff or assets. Most incidents affected staff and concerned unwelcome behaviour from service users (patients/members of the public) section 3 refers.

2.3 Non-aggression incident reporting categories include damage to Trust and non-Trust property, theft of Trust and non-Trust property, trespass and other security (for those instances where no pre-selectable code is available). Total incident numbers for these categories are:

- Other Security (93)[3];
- Trespass (45)[4];
- Damage to Trust Property (8)[5];

In separate incidents minor damage was caused by aggressive patients to a Phillips monitor and a Pulse Oximeter at RSH A&E. A building was damaged at the RSH by a delivery truck. 2 incidents involving accidental damage by confused and/or agitated patients resulted in damaged hospital fixtures; a light fitting & a window blind in one incident and the outer covering on a medical gas valve in another.

There were 4 separate incidents involving inexcusable damage to windows by aggressive patients/visitors:

[2] Source: Datix. Excludes Information Security (managed by Information Governance). Figures correct as of 20 April 2016.
[3] Insecurities, alarm activations, suspicious behaviour, suspect packages, undue interest in staff (harassment) concern regarding keys, large volume of nuisance phone calls, possession and/or use of illegal drugs by patients.
[4] Unwelcome/unnecessary presence of relatives, rough sleepers and/or intoxicated members of public in hospital grounds, unauthorised presence of public in staff only areas, refusal of patients to leave after discharge.
[5] 4 separate incidents involving damage to windows by aggressive patients/visitors (RSH OPD x1 / PRH x2 (A7E & Day Hospital) / Therapy Services Building at William Farr House site x1).

- A glazed panel on the main entrance door to the Therapy Services building on the William Farr House site in Shrewsbury was smashed after a patient refused to accept he had presented for his appointment on the wrong day;

- A window in RSH OPD was smashed after patient threw a coffee table through it by way of reaction to his wait for treatment in A&E (albeit he was still within 4 hours);

- A glazed panel on the public entrance door into the A&E waiting room at the PRH was smashed after the father of a sick child became unnecessarily frustrated at the apparent lack of attention for his child.

- A male visitor smashed in an office window after an altercation with his partner whilst outside the PRH Day hospital.

For legal reasons it has not been possible to prosecute the person responsible for the incident at the Therapy Services building, however the individual has now been banned from the premises and non-emergency treatment[6].

The perpetrator of the smashed window in RSH OPD admitted causing damage and has since paid for the damage.

The person responsible for the damage at PRH A&E initially refused to accept responsibility, but after interview under caution by police admitted responsibility and has paid for the damage. His concern regarding his child was unjustified as the child, who was not seen as high risk[7], was triaged, reviewed by Doctors and admitted to the Paediatric Ward within 40 minutes of arrival.

The person responsible for the damage to the Day Hospital window at the PRH was subsequently charged with criminal damage and following an appearance at Telford Magistrates Court, was given a conditional discharge and ordered to pay court costs of £85.

- Damage to non-Trust Property (7)[8];

- Theft of Trust Property (7) included 3 x theft of cash from car park change machines at both sites (£980:00 in total); office keys (taken when a staff members home was burgled); a wheel chair (PRH); X-Box 1 from children's Ward in the Shropshire Women & Children's Centre at the PRH;

- Theft of non-Trust Property (32)[9].

[6] Therapy Services Building, William Farr House.
[7] Confirmed by A&E Matron during post incident review.
[8] All concerned low speed collision damage to private motor vehicles parked in hospital car parks.
[9] Varied from small and significant amounts of money / loose change, (unattended) mobile phones, wallets & contents belonging to staff and patients.

3 Protecting Staff & Patients

A key principle is that staff working at the Trust, and patients and visitors using the Trust, have the right to do so in an environment where all feel safe and secure.

3.1 *Anti-Social Behaviour & Intentional Violence & Aggression*

Figures for reported anti-social behaviour and/or inexcusable/intentional violence and aggression incidents in 2015-16 are shown in Table 2. Intentional incidents ranged from acts of physical contact (however minor or inconsequential and including spitting) to threatening or intimidating behaviour, racial abuse and abusive phone calls. Intentional incidents are those incidents where the perpetrator was not deemed to have any reasonable excuse for their behaviour e.g. an underlying medical condition or illness such as dementia or toxic infection. Excess alcohol and/or drug misuse are not seen as mitigating circumstances for adverse behaviour, but rather as aggravating factors.

Table 2 - *Anti-Social Behaviour & Inexcusable/Intentional Violence & Aggression*[10]

Anti-Social Behaviour & Inexcusable/Intentional Violence & Aggression	**2013/14**	**2014/15**	**2015/16**
First quarter: Apr, May, Jun	47	30	34
Second quarter: Jul, Aug, Sep	30	38	24
Third quarter: Oct, Nov, Dec	28	21	34
Fourth quarter: Jan, Feb, Mar	42	25	40
Total	**147**	**114**	**132**

Of the reported 132 intentional violence and aggression incidents in 2015-16, 62 occurred at the RSH and 70 occurred at PRH, one occurred off site but involved staff.

28 involved physical contact (treated as 'assault' however minor or inconsequential), of these 20 were on staff (all of which were carried out by members of the public (patients/visitors) the other 8 were by patients or relatives (public) on the same.

None of the intentional physical assault incidents involving Trust staff during 2015-16 resulted in serious injury or triggered RIDDOR reporting to the Health & Safety Executive (HSE).

There were 104 intentional *non*-physical incidents i.e. incidents of verbal abuse, threatening or other anti-social behaviour, of these 93 were made towards staff.

[10] Concerning all staff (Trust and other NHS) patients, visitors and contractors. Source: Datix.

3.2 *Dealing with Anti-Social Behaviour & Inexcusable/Intentional Violence & Aggression*

In line with our published policy on dealing with violence and aggression an escalated approach is used to deal with all violent and aggressive incidents, namely:

Step 1 – Using conflict resolution techniques to diffuse situations (6.2 refers).

Step 2 – Enlisting the assistance of hospital security officers (Section 5 refers).

Step 3 – Enlisting the assistance of the police (3.4 refers).

3.3 *Post Incident Action, Sanction & Redress*

All reported security incidents from either hospital staff or the security teams are individually assessed and investigated by the Trust Security Manager. This includes liaison with staff affected by serious incident and/or their line management. The Director of Corporate Governance acknowledges each reported incident of violence and aggression (intentional or not) by writing to affected members of staff offering support through line management or occupational health and counselling services and advising of the Trust's response to incidents[11].

Where an assailant's actions were deemed to have been intentional, an entry is made on our electronic violence and aggression register. Linked to a patient's electronic SEMA record this allows staff to be warned of the potential for adverse behaviour from a patient. A warning letter, signed by the Chief Executive, is sent to the perpetrator of the adverse behaviour and copied to the victim, advising that non-emergency treatment could be withdrawn if there are any further episodes and support for police action or civil action by the Trust[12]. 52 SEMA alerts and 75 warning letters were issued during the reporting period. None of those receiving our initial warning letter during the period were reported as having been involved in further incident albeit a significant number have since returned for further treatment. A recommendation for an alert on a patient's SEMA record and the issue of a warning letter is made by the Trust Security Manager. However, prior to this action being undertaken the recommendation has to be approved and supported by a nominated medical Consultant[13]; this ensures that patients who may have lacked capacity at the time of the incident and whose circumstances may not have been accurately reflected in the incident reporting process are not unnecessarily punished.

The Trust supports all police and court actions when taken; this often includes provision of supporting CCTV, Body Worn Video (BWV) recordings or other documentary evidence. The following are some (not all) examples of other final outcomes to incidents of other aggressive

[11] During the reporting period 250 letters offering support and/or feedback to staff were sent to staff and/or department managers whose staff were involved or affected by incidents (intentional or not). In line with the strategy outlined for dealing with violence and aggression a resulting outcome is that much adverse behaviour is diverted away from medical and nursing staff by the intervention of security staff before the behaviour escalates and so medical and nursing staff can avoid injury or unnecessary involvement; by virtue of their involvement security staff, based on their early involvement become responsible for reporting on the incident with medical/nursing staff being identified as witnesses as opposed to victims. This explains in someway the disparity between numbers of support letters issued to Trust/NHS staff and all reported incidents (Tables 2 and 3 refer).

[12] It should be noted that it is not always possible or appropriate to issue a warning regarding unacceptable behaviour because a) the individual may not have been identified i.e. a visitor or someone accompanying a patient b) the circumstances of the individual deem it inappropriate c) the victim reports and/or requests immediate support to deal with an incident but wish no follow up action to occur.

[13] An A&E Consultant is nominated at each site to undertake these reviews.

and/or anti-social behaviour which resulted in police or court sanction/prosecution during 2015-16[14]:

- On the 6 May 2015 hospital security staff at the PRH were called to support nursing staff in A&E dealing with an abusive and aggressive male patient who subsequently kicked a member of staff and made a series of racially abusive comments about staff. He was subsequently arrested for common assault by police and given a conditional caution;

- Following a disturbance at the RSH on 20 June 2015 involving a male and female member of the public who were found on premises without good cause, the male person was charged with causing racially/religiously aggravated intentional harassment, alarm and/or distress following comments made towards hospital security, portering and nurse management staff;

- On the 26 June 2015 a male patient was arrested and removed from PRH A&E by police following a series of incidents which included assault on a member of West Midlands Ambulance Service (WMAS) who was working in the department, racially abusive comments about a female staff nurse and threats to security staff. He was subsequently charged with assault by beating;

- A female patient was removed from the RSH A&E early on the 1 September 15 by 4 police officers after attacking a female Doctor who she had earlier racially abused along with members of the hospital security team. The patient was subsequently charged with common assault and ordered to pay £100 compensation, a £73 fine, a £60 victim surcharge, £85 costs and given a Community Order (Rehabilitation Activity Requirement);

- Following a confrontation on 29 October 2015 at the PRH a male member of the public was convicted for assault by beating of a hospital car park attendant. For this the assailant was given a 6 month conditional discharge. This is a criminal record and is designed to serve as an incentive to prevent re-offending. If convicted of any other offence during the time of the Conditional Discharge then in addition to the sentence for that offence the defendant can be re-sentenced for the original offence as well. He was also ordered to pay £85 Court costs;

- On 20 December 2015 a male person, recently released from prison was arrested and removed by police following a confrontation with nursing and security staff at RSH A&E which resulted in damage to property and a complaint of common assault. The person of concern, who was known to police, was arrested and returned to prison (breach of Court Order) where he remained until after the Christmas and New Year period;

- An incident involving a male patient at the RSH A&E on 17 March 2016, resulted in the assault of a male Doctor (head butt) and a female student nurse whose eye was spat in. During efforts to control the patient, who was claiming to have a head injury but was subsequently diagnosed as overdosed on alcohol and drugs, a member of the hospital

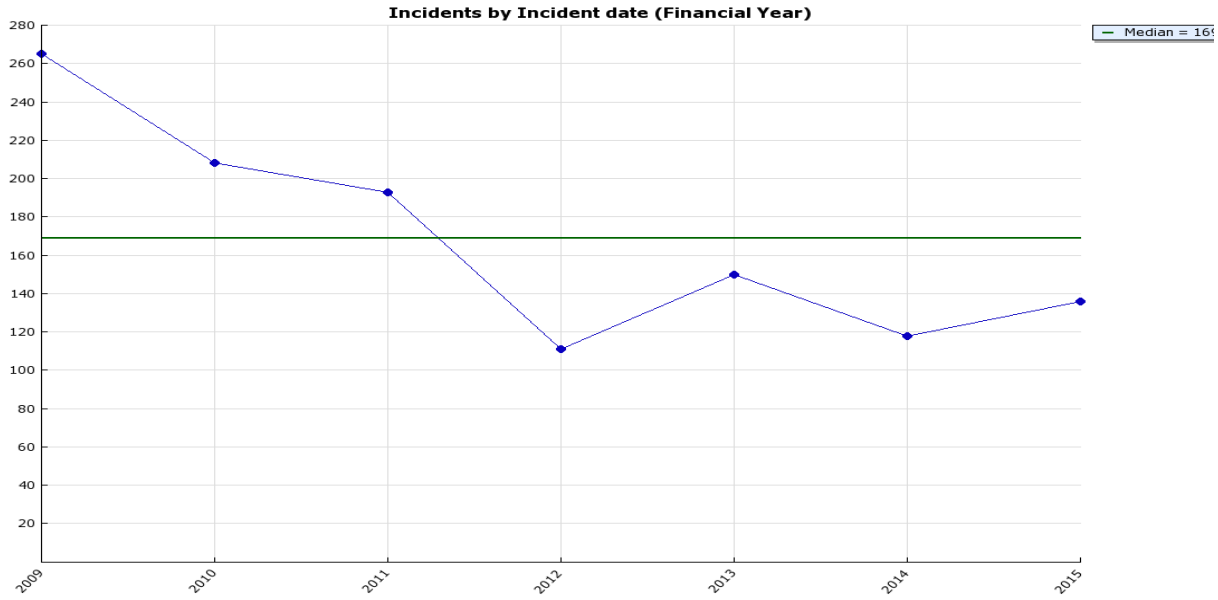
[14] For a criminal prosecution and/or other form of police sanction to take place an individual personal complaint is required; it is not always the case that staff feel able or willing to make such.

security team was subjected to some very severe racial abuse. A female police officer was also assaulted;

This matter is still under investigation by police and a charging decision is expected soon. The benefit of Body Worn Video camera equipment in the management of this incident was noted by police, with audio/video evidence preserved and submitted evidencing much of what took place.

Since 2009 and due to a number of initiatives the number of reported incidents is showing significant decreases as illustrated in Figure 1 below.

Figure 1 – Graph showing decreases in recorded instances of Anti-Social Behaviour & Inexcusable/Intentional Violence & Aggression.



Whilst the reported decreases in intentional violence and aggression since 2009 are welcome, it is recognised that the risk of adverse or unwelcome behaviour will always be present. However, where it does occur, the Trust has demonstrated that it is in a strong position to be able to control and reduce the impact and severity of intentionally aggressive behaviour.

3.4 *Non-intentional / Clinical Aggression*

These are incidents **where an individual is deemed to lack capacity** and are not therefore held responsible for their actions due to their medical condition, treatment or other underlying medical issue e.g. dementia.

Table 3a - Non-intentional Clinical Violence & Aggression[15].

CLINICAL VIOLENCE & AGGRESSION	2013/14	2014/15	2015/16
First quarter: Apr, May, Jun	105	62	75
Second quarter: Jul, Aug, Sep	86	78	84
Third quarter: Oct, Nov, Dec	91	56	84
Fourth quarter: Jan, Feb, Mar	84	102	86
Total	**366**	**298**	**329**

Of the reported 329 non intentional clinical aggression incidents in 2015-16, 196 occurred at the RSH, 132 occurred at PRH and 1 occurred at other healthcare premises, but involved Trust staff. 194 involved physical contact, 175 of these involved staff. Two of these non-intentional physical assault incidents triggered RIDDOR reporting to the Health & Safety Executive (HSE)[16].

New training for security staff in De-Escalation and (Physical) Management Intervention (DMI)[17], a revised policy for safe holding of aggressive but clinically challenged patients[18] allied to increased availability of Conflict Resolution Training (CRT), and the introduction of training in managing challenging behaviour (6.2 refers) is having a positive impact on the number of reported clinical aggression incidents *resulting in physical contact and/or injury to staff* with a 22% reduction this year (Table 3b refers).

Table 3b - Non-intentional / Clinical Physical Aggression

CLINICAL VIOLENCE & AGGRESSION – PHYSICAL	Year		
	2013/14	2014/15	2015/16
First quarter: Apr, May, Jun	65	45	55
Second quarter: Jul, Aug, Sep	63	47	41
Third quarter: Oct, Nov, Dec	67	31	36
Fourth quarter: Jan, Feb, Mar	54	74	43
Running Total	**249**	**197**	**175**

[15] Concerning all staff (Trust and other NHS) patients, visitors and contractors, source - Datix.
[16] Datix id 116871 & 121977.
[17] Training is accredited by British Institute for Learning & Development (BILD) and the Institute of Conflict Management and is provided by colleagues from South Staffordshire & Shropshire (Mental Health) Foundation Trust (SSSFT). Since the initial foundation course undertaken by core team security staff in Dec 2014 annual refresher training for the same was completed in Dec 2015; a further 5 day foundation course for a number of new security staff was completed in Feb 2016.
[18] Provides assurance towards requirements of NICE Guidance NG10 (violence & aggression: short-term management in mental health, health and other community settings).

The assertion that non-intentional clinical physical aggression incidents has lowered is supported by the fact that numbers of overall reported clinical aggression incidents remains broadly consistent (Table 3a) as would be expected given our patient population has not decreased and the numbers of non-physical clinical aggression incidents has risen (Table 3c) i.e. we still have difficult and challenging patients to care for, but better management of their physical aggression and/or potential physical aggression had led to less physical contact, harm or injury for staff and/or other patients.

Violence & Aggression - Table 3c (Clinical - non-physical)

CLINICAL VIOLENCE & AGGRESSION - NON PHYSICAL	Year		
	2013/14	**2014/15**	**2015/16**
First quarter: Apr, May, Jun	40	16	19
Second quarter: Jul, Aug, Sep	23	29	34
Third quarter: Oct, Nov, Dec	28	25	41
Fourth quarter: Jan, Feb, Mar	32	32	41
Running Total	**123**	**102**	**135**

A more complete picture will be evident when another years figures are available, however evidence of increasing staff awareness on the revised policy, and confidence in security teams to provide appropriate support, is demonstrated below in Table 3d[19].

Violence & Aggression - Table 3d (number of safe hold interventions by security staff 1 June 2015 – 31 March 2016).

Month	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number	13	14	14	26	23	22	25	24	25	34

Not all 'safe holds' were undertaken as a result of actual aggression towards staff. The reasons some were undertaken are described herewith:

- At the direct request of medical and/or nursing staff to ensure a patients safety during a planned invasive procedure where the patients mental or physical state, whilst not aggressive, suggested to medical/nursing staff that harm or injury to the patient or staff would almost certainly have ensued during the procedure;

- To prevent patients in personal crisis from attempting and/or carrying out acts of self-harm;

- To see the safe and prompt return of absconded, high risk, confused and/or agitated patients to the hospital buildings and/or their ward/bed spaces and avoid adverse outcome

[19] Data collection for this began on 1 June 15 but numbers of safe holds during April and May were certainly less than 10 holds in each month.

for them and/or staff involved in the process of 'returning the patient'.

It is recognised that the risk of clinically related aggressive behaviour will always be present in an organisation like ours, not least due to consistent pressures from an ageing population in Shropshire which is above the national average and pressures on providers of community care, which often result in an unwelcome and pro-longed stay in the acute hospital setting for patients who require more focused support in a more appropriate setting.

3.5 *Lone Working*

The Trust has a two-track strategy, one for off-site lone workers or those out in the community and one for those working alone on-site.

(i) Off-Site Strategy

The lone worker device used is a nationally introduced model in the form of an identity badge holder worn around the neck or clipped to a belt or tunic. This includes a panic alarm that can be discreetly activated and which automatically opens a line of communication (via mobile phone networks) to a national Alarm Receiving Centre (ARC), thereby allowing situation assessment and immediate response, as well as recording of evidence. The scheme and the ARC have been assessed and accredited by the Association of Chief Police Officers (ACPO). Response to an alarm activation can include an emergency police response as the ARC is linked as part of the ACPO accreditation, to all local police operations rooms. The ARC staff are able to directly feed live information from the staff members device and pre-recorded information on where the staff member is located, to the nearest police control room. The advantage here is that police response is quicker because the information being received by them is from an accredited source and is fed straight into police control rooms. Other available lone worker schemes and devices do not provide an ARC with a set up equal to the one described or with the same level of police involvement. Some lone worker device products do offer GPS technology which is often claimed to be more reliable in terms of signal although this is not always the case, equally these devices do not have the opportunity for staff to state what address they are at. The GPS alternative is less effective as it might put a member of staff at a location, but if that location were a block of flats it would not be possible to determine which flat or floor level they were at or on.

The device is not seen as a risk eliminator, rather as a risk reducer designed to work with and complement other safe systems of work, thereby representing a significant improvement on what had been previously available to staff. If staff are concerned that their device consistently suffers from poor network service provision they can contact the Service Desk and where appropriate, if better coverage on another network can be achieved, the Service Desk will arrange a 'SIM swap' to that network. The Trust has a total of 253 devices in use and issued to staff who work alone in the community (regularly and/or occasionally). During the reporting period, 7 additional members of staff were trained on lone worker device usage and given use of devices, either as new starters/replacement staff within existing user departments or as staff identified as now being at risk.

(ii) On-Site Strategy

In this system, upgraded hospital pagers allow a lone worker to send a discreet emergency alert to security staff pagers and hospital switchboards. As well as being used on a daily basis by staff in departments whose role or task requires continual support e.g. overnight Pathology Laboratory staff, devices have also been used to provide immediate short term reassurance to staff who through no fault of their own have become the victim of undue interest from members of the public. This system was chosen due to excellent signal reliability when used anywhere on the hospital sites; mobile phone and other signals are poor in many areas due to building construction/constraints. Many of the users of these devices are employed in static locations making them high risk lone workers due to their inflexibility to move location and because would be offenders may in time become aware of the staff members location.

3.6 *Baby Tagging*

This facility was included in the new build Shropshire Women and Children's Centre on the Post-Natal Ward. Since the building opened, feedback on the system has been positive and to this end the system was extended during the reporting period through kind support of the League of Friends (Telford) to provide full cover to the Ante-Natal Ward which is our standby post-natal overspill facility. Checks and testing of the system (which also installed on our main Midwife Led Unit (MLU) at the RSH) and staff reactions is carried out on regularly by the Lead Midwife for Acute and Outpatient Services and Trust Security Manager.

3.7 *CCTV, BWV & Manned Guarding*

Information concerning the development and use of CCTV, BWV equipment and Manned Guarding is covered at paragraph 4.2 and section 5.2 respectively.

4 Protecting Property & Assets

All those who work in, use or provide services to the NHS have a collective responsibility to ensure that property and assets relevant to the delivery of NHS healthcare are properly secure. This includes physical buildings and equipment, as well as staff and patient possessions.

4.1 *Access Control & Intruder Detection*

Continued restrictions in capital funding/investment have curtailed opportunity for realising security (capital) aspirations to see expansion of the Trust networked swipe card door access system to departments on either site. Notwithstanding this, progress has been made in recent years with its inclusion in new build projects and major refurbishments, such as Shropshire Women & Children's Centre, The Lingen Davies Centre for cancer and haematology and RSH Pathology reconfiguration works.

During this reporting year swipe card door access control was included in the £1.2 million refurbishment of the RSH mortuary. The hospital Mortuary is an important element of our Pathology operation and ensuring the new facility meets current and future assurance and audit expectation, not just in terms of physical robustness but also user accountability, is vital.

Other additional access control was included in work that saw the enlarging of the PRH A&E department; opportunity was also taken to address some historical concerns and vulnerabilities with access control elsewhere in the department, therein providing more reassurance for staff working at night time.

Progress was also made towards improving other physical security arrangements across the Trust, notably through the installation and use of intruder alarm systems to take advantage of our 24/7 switchboards and on-site security staff presence which ensure a rapid response and intervention in the event of an alarm activation. Areas of improvement included:

- RSH Children's Assessment Unit; to allow compliance with Medicines Code for storage of Controlled Drugs when the Unit is closed;

- RSH Medical Engineering department; a target hardening measure following assessment of the departments security out of hours identified unforeseen vulnerabilities that have only arisen as a consequence of the Copthorne Building now being empty of staff out of hours;

- RSH Mortuary; installation of an intruder alarm system. Ensuring appropriate arrangements for maintaining security and dignity of the deceased during this period of disruption was a priority.

4.2 *Closed Circuit Television (CCTV)*

The significant security advantage gained from the opening of our site CCTV camera control rooms at the RSH and PRH in recent years continues. The facilities have proved particularly helpful in the rapid investigation of missing patients, some of whom have either inadvertently or intentionally left the hospital buildings.

During the reporting period both hospitals have benefited from the installation of additional CCTV cameras at each site.

At the RSH this included meeting long term aspirations to extend CCTV coverage to all areas of the hospital building, namely:

- 5 cameras in and around Pharmacy; a target hardening measure to assist with security aspects of an on-going Home Office license application[20];

- General Office/Cashiers Office (1 camera) & public ATM/Cash Machine (1 camera); target hardening measures to recognise increased activity at General Offices and in terms of the ATM to protect and provide reassurance to vulnerable patients from Fraud.

Both installations will also help with patient safety by way of assisting security staff to quickly track and find absconded patients who may be either in crisis or lacking in capacity. To supplement access control and intruder alarm arrangements at our refurbished Mortuary, 1 additional CCTV camera was installed in the hospital grounds and a number of existing cameras in the area were re-positioned to provide more favourable coverage and assurance for staff, public and visitors arriving at the facility, often out of hours.

At the PRH we extended coverage of the A&E department as part of the department expansion with an additional 5 cameras.

The output from all of these cameras is fed back to the site CCTV camera control room where images are stored and controlled in accordance with our CCTV operating policy. CCTV equipment at all our sites is covered by 24/7 call out maintenance support contracts, which includes at least 2 annual service inspections by a qualified engineer from our preferred contract support company, ADT. Through the year a number of failed items of equipment (cameras (internal and external), monitors and ancillary operating equipment were replaced or repaired.

[20] Concerning new business to support community hospital pharmacies.

5 Manned Security Service

Security staff provide a general deterrent by their presence to all manner of threats including violence and aggression, theft, vandalism etc. Although security staff at both sites are provided by a parent company, they are very much seen as part of the hospital team and relied upon heavily for support across all areas of both hospitals (Appendix 1 refers).

5.1 *Contract Re-tender*

The Trust's manned security guarding contract expired on 1st December 2015. Trust Procurement staff managed a re-tender process for this contract supported by the (NHS) London Procurement Partnership who undertake procurement work for and on behalf of NHS organisations. In particular, they operate a framework agreement that is a straightforward way of compliantly accessing a full catalogue of contracts which have already been through a fully EU compliant tendering process, therefore removing the need for the Trust to engage in complex and lengthy EU procurement processes.

7 security suppliers had previously been awarded onto the Framework; 2 of these issued a submission for our contract to run from 1 December 2015 for 2 years with the option of a further 2 years should it be deemed appropriate. Initial quality and financial envelope submissions by each supplier were evaluated and scored[21]. On 1 October 2015 a presentation panel led by Julia Clarke, Director Corporate Governance (lead Executive for security) evaluated presentation by both companies in response to set questions and outlining company overviews. The evaluation process identified that Corps Security were best placed to provide the Trust with manned guarding services through award of a 2 year contract with the option for year 3/4 extensions. Costs for the new contract are £325k for year 1 and year 2. The majority of our existing security staff on our core teams working at both hospitals took the option to transfer to the new contract under TUPE[22].

Previous manned guarding contract costs were £340k per annum, so the current contract resulted in a contractual saving of £24,127.74, plus a £3k provision for a pooled performance scheme for Security Officers, resulting in an overall saving of £21,127.74. Quoted hourly rates for staff reflected the implementation of the then forthcoming National Living Wage (NLW) increase to £7.20 per hour from 1 April 2016, which Corps Security awarded from 1 December 2015.

5.2 *Numbers & Role of Security Officers*

There are two officers on duty at each of our main hospital sites on a 24/7 basis with a named supervisor who rotates between each site to ensure regular contact with all officers. The contract is manned by a core team of a supervisor plus 12 officers, supported by named relief officers. The aim being that these relief officers work regularly at the hospitals to maintain competencies and recognise the skill sets required of security staff working at hospitals as opposed to less demanding and more traditional security settings.

[21] 10 September 2015 by Jon Simpson (Trust Security Manager/LSMS), Paul Higginson (Procurement) Tricia Penney (Finance). The Quality Assessment Offer Schedule considered the following areas; Delivery of the Services 18%; Management Capability & Capacity 18%; Staff Retention/Motivation 18%; Training 3%; Service Delivery Failure 9%; Environment/Sustainability 6%.

[22] Recruitment to fill vacancies left by those who chose not to transfer and strengthen security manpower levels has been since been undertaken resulting in the welcome arrival of a number of new staff.

Security Officers attended the majority of all reported security incidents. With any aggression incident they are called to help provide reassurance and assistance in seeing the safe closure of the incident or prevent further escalation, as well as providing pre-arranged preventative support to staff to stop a foreseeable incident occurring or escalating. This may be as a result of a noted security alert against a patient or by support to midwife and social service teams planning/overseeing safeguarding transfer of a new born.

Security Officers at Shrewsbury remain linked via radio into the local 'Safer Shrewsbury' shop watch/pub watch network, which affords immediate access to local police support, acts as an early warning mechanism should problems be experienced in the local area and allows for sharing of intelligence and information on persons of concern to the local community. The scheme has proved successful in contributing to a reduction in anti-social behaviour and crime in Shrewsbury town centre[23], an outcome which benefits the Trust in a number of ways. The Partnership has also directly intervened to punish offenders when it has been seen that reported behaviour at the hospital stemmed from earlier misuse of alcohol purchased at member's premises (where they were also misbehaved)[24]. No similar scheme operates in Telford and Wrekin district; however, Security Officers at the PRH are able to communicate with each other via two way radio.

With non-intentional/clinical aggression security staff provide assistance and support to medical and nursing staff to ensure no harm comes to either patients or staff. To provide security staff with the skills and confidence to do this, specialist DMI training (6.1 refers) is delivered to security teams by accredited NHS training staff from South Staffordshire & Shropshire Mental Health Foundation Trust (SSS(MH)FT). There is evidence from incident reporting that suggests introduction of this training, along with a revised policy of safe handling of clinically aggressive patients[25] has resulted in significant reductions in the number of staff being harmed or injured through physical contact with clinically aggressive patients (3.4 / Table 3b, 3c & 3d refer).

Security Officers provide daily occurrence reports and specific written reports for incidents dealt with by them. Whilst security incident reporting is based on the report submissions by hospital staff (Datix) and Security Officers (written report), it should be noted that Security Officers attend a large number of requests for assistance which are seen as 'preventative support' i.e. by virtue of their attendance the concern that required their attendance either stops the matter escalating and/or prevents an incident from even occurring e.g. when staff note a SEMA warning alert for aggressive tendencies by a patient which will trigger a request for security staff presence.

Security staff also contribute to a wide range of tasks which are not specifically recorded as security incidents, but occur on a daily basis, these include:

[23] Safer Shrewsbury Pub Watch Annual General Meeting (AGM) 22 Apr 2015.
[24] Safer Shrewsbury Partnership Annual Report 2014 dated 22 Apr 2015.
[25] Policy for Clinical / Safe Holding of Adults and Children Receiving Care in the Trust.

- Help with searching and locating absconded or missing patients or patients in crisis who are deemed to be vulnerable and/or at high risk of self-harm or taking flight (patient safety incidents)[26];

- Fire alarm activations and other fire incident related activity (fire safety incidents)[27];

- Attendance at Air Ambulance arrival/departure (operational task);

- Emergency resuscitation team calls to victims in public areas of the hospitals to ensure resuscitation teams can work without disruption or oversight of victims and ensure safe passage for patient evacuation etc. (medical emergency task);

- Escort of General Office staff carrying out cash transfer and filling/emptying of change machines and collection of valuables from night safes (cash security)[28].

Additional security staffing was also put in place on key dates during the Christmas and New Year periods. There were six separate occasions where additional one to one security was provided 24/7, for either days or weeks, for particular patients whose treatment or behaviour was of particular concern in terms of the safety of other patients and/or staff.

All core team security staff and regular relief staff are now 'mask fit tested' in order to allow security staff support with our Flu Pandemic plans.

5.2 *Body Worn Video Surveillance (BWV) Equipment*

BWV surveillance equipment incorporating both image and audio recording was introduced on 1 Apr 2012 as a means of preventing anti-social and aggressive behaviour and is worn by Security Officers at both hospital sites. The equipment (six units in all) continues to have a significant impact on reducing anti-social and/or aggressive behaviour (3.3 refers). A statement on how the equipment is used and controlled is included within our published CCTV policy.

[26] 128 reported occurrences by security staff of doing this.
[27] 79 reported occurrences by security staff of doing this.
[28] Every day (Mon-Fri) for patient valuables collection from hospital safes and thrice weekly for emptying/replenishment of car park change machines.

6 Communication, Awareness & Training

Efforts continue to raise staff awareness on security matters and encourage a proactive security culture and the numbers of reported incidents reflects this. When appropriate, global e-mail alerts and warnings have been sent out to all recipients in the Trust. These include specific information received from the NHS Protect on persons of concern who have gained attention for adverse behaviour at national and regional level. These alerts are distributed on receipt to security teams and staff at admission points at both sites. Regular updates are sent out to staff on security improvements through Trust communication channels.

6.1 *De-Escalation & Management Intervention (DMI) for Security Staff*

With non-intentional/clinical aggression security staff provide assistance and support to medical and nursing staff to ensure no harm comes to either patients or staff. To provide security staff with the skills and confidence to do this specialist DMI training is delivered to security teams by accredited NHS training staff from South Staffordshire & Shropshire Mental Health Foundation Trust (SSS(MH)FT).

The training, which consists of a 5 day foundation course and annual refresher days thereafter, has been accredited by the British Institute for Learning & Development (BILD) and the Institute of Conflict Management. A syllabus ordinarily delivered to NHS Mental Health professionals working at SSS(MH)FT is followed, but with additional bespoke content aimed at recognising the role of our security staff and the varied and different circumstances and settings experienced in a busy acute hospital environment.

In the reporting period our contract supervisor and 6 core team security staff undertook their annual refresher training whilst 5 new staff completed the 5 day foundation course.

6.2 *Conflict Resolution Training (CRT)*

Learning & Development colleagues provide CRT for staff using the NHS Protect national approved syllabus. CRT was undertaken on 1215 occasions during the period, namely:

509 face to face 3 hour sessions delivered to staff;

180 face to face 3 hour sessions for new HCA recruits as part of their pre-employment training/induction[29];

74 junior medical staff via e-learning induction[30];

452 other staff via e-learning.

As part of a new approach to training from April 2015, we have introduced training which focuses on skills for managing challenging behaviour. This training, which is based on guidance released by NHS Protect and endorsed by numerous national bodies involved in or responsible

[29] Previously identified the staff group most vulnerable to experiencing acts of violence and aggression (source Datix).
[30] Face to face training for junior medical staff is undertaken by the West Midlands Deanery.

for care of such patients or those staff being asked to care for them[31], is delivered by medical consultant staff from CCG RAID Teams and is funded through existing financial provision within the NHS Standard Contract between the Trust and its CCG's. During the reporting period 80 clinical staff received this training.

There is evidence from incident reporting that suggests introduction of DMI training (6.1 refers) along with a revised policy of safe handling of clinically aggressive patients[32] and progress with increasing the numbers of staff undertaking Conflict Resolution Training (CRT), has directly resulted in significant reductions in the number of staff being harmed or injured through physical contact with clinically aggressive patients (3.1 & Table 3b, 3c & 3d refer).

6.3 *Corporate Induction*

During the period, 840 staff members were given security and fraud awareness briefings and training at Corporate Induction by the Trust Security Manager[33].

6.4 *Lone Workers*

During the reporting period 7 members of staff who work alone in the community (regularly and/or occasionally) were trained on lone worker device usage and personal security. All staff using lone worker devices for use under the off site strategy are given training by the service provider prior to a device being enabled. The training not only informs on how to use the device in terms of practicalities like switching on and off and battery charging, but also informs on the risks to lone workers identifying vulnerabilities and risk assessment.

6.5 *Local Security Management Specialist (LSMS) Forum*

The Trust Security Manager attends quarterly meetings of the West Midlands area LSMS. This is an important forum and provides opportunity for briefing and discussion on the latest security issues affecting NHS interests in the West Midlands and nationally, and has a range of speakers from the security industry and health sectors.

6.6 *Mask Fit Testing*

Our security contract supervisor attended mask fit training in February 2016. He can now ensure all security staff are mask fit tested, both core team and regular relief staff. This ensures records exist for security team responsibilities in the event of a flu pandemic.

[31] Meeting needs & reducing stress (NHS Protect 2013).
[32] Policy for Clinical / Safe Holding of Adults and Children Receiving Care in the Trust.
[33] Figures from Learning Development 18 Apr 2016.

7 Conclusion/Year Ahead

In addition to maintaining and progressing *all* of the activity already covered by this report, in particular administering and responding to reported incidents, we will also seek to:

- Further develop security CCTV facilities at the RSH by investigating means of monitoring CCTV camera outputs on outlying sites, such as the Boiler House and Recycling compound, by main site CCTV camera control rooms and continue to fill in gaps in our CCTV capability at both sites.

- Continue developing links with local police and other partners to ensure clear messages regarding unwelcome and anti-social behaviour to reinforce the Board's robust approach to abuse of staff and patients.

- Implement a program of work to see the re-organisation of our systems for producing and managing staff photographic identity cards including a complete re-issue of all current staff badges[34].

[34] Program plan approved at Trust Executive 4 May 2016.

Appendix 1 - Supplementary Information on Manned Guarding.

From: Williams Becky (A&E Sister)
Sent: 08 January 2016 03:51
To: Simpson Jon (Security Manager)
Subject: great security team

Hi I would just like to commend the professionalism of the security staff on duty on new year's eve night shift and news year day night duty (Paul & Brett). As you can understand the Emergency Department was very busy full of very intoxicated people that were at times difficult to manage by the nursing staff. Although were dealt with by security with patience and professionalism, appropriately diffusing situations whenever possible.

They truly are an asset to the ED team.

Please can you pass on our many thanks.

Kind Regards

Sister

Rebecca Williams

RSH

From: Kirk John on behalf of Communications
Sent: Thu 01/10/2015 13:47
To: Simpson Jon (Security Manager)
Cc: Communications
Subject: Congratulations! Invitation to SaTH Heroes Reception

Dear Jon

The Security Team at PRH have been named as SaTH Heroes and are cordially invited to a reception with some of our Directors ***in the Education Centre at the Princess Royal Hospital in Telford at 10.30am on Friday 16 October 2015.***

Please could you confirm your attendance (and how many members of the team will be able to attend) via RSVP by Friday 9 October 2015 to John Kirk, Communications and Engagement Manager, by emailing john.kirk@sath.nhs.uk or calling RSH Extension 2285.

John Kirk
Communications and Engagement Manager

The Shrewsbury and Telford Hospital NHS Trust | Royal Shrewsbury Hospital | Mytton Oak Road | Shrewsbury | Shropshire | SY3 8XQ

Telephone 01743 492285 |
Email john.kirk@sath.nhs.uk |

Hi Jon

I am sending you this email on behalf of ward 17 staff who would like to pass on their thanks to your wonderful security team who have been assisting us over the last week or so with one of our very agitated patients.

We have felt very well supported by your team and felt we should let you know so you can pass on our thanks.

Many Thanks again
Sr Sharon Hollister
☺ ☺