

Paper 18

Recommendation <input checked="" type="checkbox"/> DECISION <input type="checkbox"/> NOTE	<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Trust Board</div> is asked to Approve 2017-18 Annual Security Report
Reporting to:	Trust Board
Date	31 May 2018
Paper Title	2017-18 Annual Security Report (full report included in Information Pack)
Brief Description	<p>Under the provisions of the NHS Standard Contract, Providers are required to have in place and maintain security arrangements in their organisations. Commissioners are required to review these arrangements. By way of assurance for Commissioners the Trust publishes an annual security report. The report for 2017-18 is attached for approval. Points of interest are highlighted herewith:</p> <ul style="list-style-type: none"> • Security management involvement in a range of Corporate Governance, Estate development and Trust operations continues as well as increased collaborative working with partner agencies. • Reported/recorded instances of anti-social behaviour / intentional violence and aggression in 2017-18 are 58% less than for 2009-10. Staff safety in relation to this matter continues to benefit from the rigid application of our policy and stance on tackling violence and aggression, including more efficient use of and better trained security teams as well as collaborative working with police. Use of warning letters and in a number of cases escalated attention and/or prosecution have all ensured the gaining of meaningful sanction and redress and the limiting of re-offending. These outcomes were acknowledged in positive NHS Staff survey results. • Reported/recorded instances of physical harm or injury to staff from confused or agitated patients (non-intentional violence and aggression) were 13% less during 2016-17 than 2014-15. Notwithstanding intense winter pressures and further increases in patient numbers during 2017-18 by comparison with 2014-15 we have still seen 7% less instances of physical harm or injury to staff from confused or agitated patients during 2017-18. • Additional security for new borns introduced onto MLU. • 2 year manned security contract secured with new provider. Security team effort recognised with VIP award. • Despite operational pressures over 900 staff undertook face to face Conflict Resolution Training (CRT); over 500 other staff accessed CRT e-learning.
Sponsoring Director	Julia Clarke, Director Corporate Governance
Author(s)	Jon Simpson, Trust Security Manager
Recommended / escalated by	Audit Committee, 25 May 2018
Previously considered by	H&S Committee, 24 April 2018

Link to strategic objectives	<p>SAFEST AND kinDEST: Our patients and staff will tell us they feel safe and received kind care.</p> <p>OUR PEOPLE: Creating a great place to work</p>
Link to Board Assurance Framework	<p>If we do not achieve safe and efficient patient flow and improve our processes and capacity and demand planning then we will fail the national quality and performance standards (RR 561).</p> <p>If we do not develop real engagement with our staff and our community we will fail to support an improvement in health outcomes and deliver our service vision (RR 1186).</p> <p>If we do not get good levels of staff engagement to get a culture of continuous improvement then staff morale & patient outcomes may not improve (RR 423).</p> <p>Risk to sustainability of clinical services due to shortages of key clinical staff (RR 859).</p>
Outline of public/patient involvement	<p>N/A</p>
Equality Impact Assessment	<ul style="list-style-type: none"> <input checked="" type="radio"/> Stage 1 only (no negative impacts identified) <input type="radio"/> Stage 2 recommended (negative impacts identified) <ul style="list-style-type: none"> * EIA must be attached for Board Approval <input type="radio"/> negative impacts have been mitigated <input type="radio"/> negative impacts balanced against overall positive impacts
Freedom of Information Act (2000) status	<ul style="list-style-type: none"> <input checked="" type="radio"/> This document is for full publication <input type="radio"/> This document includes FOIA exempt information <input type="radio"/> This whole document is exempt under the FOIA

Annual Security Report

2017-18

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.

Terry Mingay is the Designate Non-Executive Director responsible for security management at Board level since January 2018, with Harmesh Dharbanga as the Lead Non-Executive Director up until that point.

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.

12 April 2018

Julia Clarke
Director Corporate Governance

Terry Mingay
Designate Non-Executive Director

Section	Contents	Page
	Title Page	1
	Foreword	2
	Contents	3
1	Governance	4
2	Security Incident Reporting	9
3	Protecting Staff & Patients / Property & Assets	10
4	Communications, Awareness & Training	21
5	Conclusion	23
Appendix 1	Extract from Security Team VIP Award Nomination	24

1 Governance, Risk & Assurance

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. Aside from publishing this Annual Report, the Trust will also prepare an evidenced based Self-Risk Assessment (SRA) set against 30 national security standards. Work will commence shortly to prepare our 2018-19 assessment, based on results and outcomes from 2017-18.

1.2 *Policy*

The following security policies (and corresponding EQIA) were reviewed during the reporting period.

- Security Management (June 2017 v1.9);
- Lockdown (September 2017 v1.7).

Security management advice and input was provided during reviews of Trust policy on:

- Information and Information Systems Security;
- Clinical / Safe Holding of Adults and Children Receiving Care in the Trust;
- Medicines Code;
- Absconding/Missing Patient policy.

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 Head of Assurance 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 appropriate Tier 2 committee.

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 *Security Risk Assessment*

General security risk assessment and Lock Down assessments are included within the Health & Safety element of the 'Exemplar Ward' program. This important development provides ward management teams with direct access to security risk assessment tools and templates as well as sign posting specialist security management/LSMS support if/when required as well as complying with Service Condition 24 of the NHS Standard Contract. Security risk assessment advice, guidance and documentation were provided to Wards 5, 10, 11, 15, 17, 21 & 32 during the period.

Security risk assessment advice, guidance and documentation was also provided to a number of departments listed herewith (not all):

- Patient Access: Concerning medical records storage areas and concern around lone working and Lock Down at both sites;
- Fertility & EPAS: Entire service re-location from RSH to Severn Fields Health Village, Sundorne, Shrewsbury. Areas of work include access control, lone working and security infrastructure arrangements;
- Wrekin Antenatal at PRH regarding storage and handling of cash and use of new Baby Tagging system;
- Estates Capital Projects Team: Concerning the development of the new build Urgent Care Centre (UCC) and Clinical Decision Unit (CDU) at the PRH;
- Ophthalmology & Estates Capital Project Team: Concerning the re-development of Ward 20 in the Copthorne House building at the RSH (replacement for the ICAT, Euston House, Telford);
- Therapy Services: Concerning the provision of CCTV to the reception area of the Therapy Services building on the William Farr House NHS site, Copthorne, Shrewsbury;
- Corporate Governance Team: Concerning use of off-site car parks for parking pool car vehicles;
- Pathology: Location and security aspects of using an additional temporary Body Store at the RSH during winter escalation;
- Keele Undergraduate Medical School: Concerning additional security improvements to the RSH Learning Centre.

1.5 *Committee Work*

The Trust Security Manager attends all Health, Safety & Security Committee meetings. This committee, chaired by the Head of Assurance, meets quarterly, and fulfils the Trust's requirement to have a Security Committee. Security is embedded as a standing item in 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 monthly Operational Risk Group (ORG) meetings. Chaired by the Head of Assurance, this ensures security management oversight and advice is readily available for all matters discussed or raised.

The Trust Security Manager attends monthly 'Team Shrewsbury' committee meetings. Chaired by a local Police Inspector, these meetings are a multi-agency approach to tackling community issues and problems including anti-social behaviour. The committee acts as an early warning mechanism should problems be experienced in the local area and allows for sharing of intelligence and information on matters of concern to the local community. Additionally the forum offers networking opportunities with key partners.

The Trust Security Manager attends the Staffordshire & Shropshire Controlled Drugs (CD) Local Intelligence Network (LIN) forum. This forum is an excellent awareness sharing mechanism for a key area of medicine management where a high level of assurance is necessary.

The Trust Security Manager is a member of the Staffordshire & Shropshire NHS LSMS forum. Following the drawdown of NHS Protect in 2016-17 as the national body for coordination of security management in the NHS, this voluntary forum is attended quarterly by LSMS from the area and all NHS sectors including Acute, Mental Health and Community services and provides opportunity for briefing, discussion and awareness raising on the latest security issues affecting Trust interests.

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

Release of Information

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 8 occasions. These releases concerned 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. 1 release was made to Human Resources (HR) colleagues to assist with a disciplinary investigation and 1 release was made to H&S colleagues to assist with a patient fall Root Cause Analysis (RCA) inquiry.

FOI

25 FOI requests were made regarding other security matters and reported incidents at the Trust. Responses and data were provided to Corporate Governance staff that coordinate and oversee Trust responses.

Complaints

Claims by a relative, that her husband, who had left his Ward, on a day in July 2017, had been mistreated by a member of our security team was not upheld due to contradictory facts given in the complaint as regards timings and location and other witness evidence. The matter was included as part of a general response about the patients experience from the Complaints Team and the matter closed.

Concern was raised by a member of the public in October 2017 regarding his receipt of a warning letter from the Trust about his behaviour when attendant at the RSH A&E department in August 2017. His concern that his behaviour was not as claimed by staff and witnesses was discounted after the matter was independently reviewed by the Trust Legal & Compliance Manager whose findings upheld the original decision to send the warning letter. This review included Body Worn Video evidence of the incident which had been preserved immediately after the incident.

Claims by a patient that she had been mishandled by security team in the hospital grounds in November 2017 was not upheld when it was established that she had been safely handled using an approved technique. This was done in her best interest and at the request of nursing and medical staff who were concerned for her safety after she left the Surgical Admission Unit (SAU) at the RSH without reason and needed to be returned so her treatment care could be safely concluded. The matter was included as part of a general response about the patients experience from the Complaints Team and the matter closed.

A patient claimed that he had on one occasion been beaten by security staff whilst attendant at the RSH on a date in August 2017. He also claimed that on other occasions between August and October 2017 he had again been mishandled by security staff and his mobile phone damaged by them whilst attendant at both RSH & PRH A&E departments. These claims were discounted on review which included available CCTV and Body Worn Video evidence. Matters concerning the attendance at both hospitals of this patient have since been the subject of police interest and prosecution (3.3 refers). All of his errant behaviour is attributed to his refusal to leave A&E departments after treatment.

In a formal complaint made to the Trust in February 2018 about her (PRH) A&E experience and care, a female patient alleged that a member of security team used the F word during a conversation. This accusation was denied by the Security Officer concerned who identified witnesses to support his rebuttal. The matter was included as part of a general response about the patient's experience from the Complaints Team and the matter closed.

1.7 Assurance

Baby Tagging; during the year we regularly tested our Baby Tagging security systems to ensure system operability and staff knowledge and reactions. Organized and overseen by the Trust Security Manager and Post Natal Ward Manager these tests are conducted every 3 months. Results of each test are fed back to senior Women & Children's management, Director of Corporate Governance and Head of Legal & Security services. The process was extended to include the Wrekin Maternity Midwife Led Unit (MLU) at the PRH towards the end of 2017. The RSH MLU will be included in the testing program once the Unit re-opens in April 2018 following structural repair to the roof.

Lock Down; every 3 months our security team supervisor undertakes audit and functionality tests of the Lock Down plan for each of our A&E departments. This ensures that paper copies of said plans are in the place staff expect them to be should they need them, are the correct version and the instructions contained therein and the systems and facilities so described are correctly functioning. Whilst this is being done opportunity is provided for (new or less frequent working) A&E staff to walk the department and understand the plan first hand. At the same time security staff check the viability, effectiveness and likelihood of each ward and main departments towards achieving a dynamic simple lock down. Any serviceability issues can be

addressed therein and the occasion also gives opportunity to liaise with ward staff and highlight the procedure and mechanism for securing departments which by virtue of their daily operation are seldom locked and secured. Records on all these audits are collated and retained by the Trust Security Manager.

Lone Working; In recognition of those staff working 'on site' our security team supervisor undertakes regular (3 monthly) audit and test of Lone Worker pagers issued to/held by departments to ensure availability to staff and equipment functionality through testing with Switchboards.

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. Staff are also supported by the security team who can undertake incident reporting for the member of staff post incident/after discussion.

2.1 Comparative figures for 2017-18 are shown in Table 1¹.

Table 1 - Security Incident Reporting

ALL SECURITY INCIDENTS	2014/15	2015/16	2016/17	2017/18
	First quarter: Apr, May, Jun	133	143	148
Second quarter: Jul, Aug, Sep	147	153	140	157
Third quarter: Oct, Nov, Dec	118	197	158	159
Fourth quarter: Jan, Feb, Mar	169	182	141	167
Running Total	567	675	587	667

2.2 Of the reported 667 incidents in 2017-18, 404 occurred at the RSH, 263 occurred at PRH.

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 (153)²;
- Trespass (36)³;
- Damage to Trust Property (22)⁴;
- Damage to non-Trust Property (4)⁵;
- Theft/alleged theft of Trust Property (5)⁶;
- Theft/alleged theft non-Trust Property (26)⁷.

¹ Source: Datix. Excludes security related Information Governance incidents which are managed by Information Governance. Figures are as available/recorded with effect 1 April 2018; this applies to all figures contained within this report hereafter. Figures may be subject to increase thereafter due to late reporting and/or incidents being re-coded from other categories during end of year accounting/verification.

² Examples include building/office insecurities, alarm activations, suspicious behaviour, suspect packages/items left unattended, undue interest in staff (harassment), concern regarding whereabouts of keys, nuisance phone calls, possession and/or use of illegal drugs by patients.

³ Examples include 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.

⁴ Examples include damage to windows, doors and fixings in wards/clinics by confused patients and/or persons/patients acting irresponsibly.

⁵ Relating to low speed collision damage to private motor vehicles in hospital grounds and/or other unexplained damage to the same.

⁶ Theft of food items from catering outlets, an ESR smart card and a blank FP10 prescription form.

⁷ All concerning theft or alleged theft of cash from staff or patients aside from 1 instance concerning a mobile phone and one concerning personal items from a desk.

3 Protecting Staff & Patients/Protecting Property & Assets

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. Equally 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.

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

Figures for reported anti-social behaviour and/or inexcusable/intentional violence and aggression incidents in 2017-18 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 as aggravating factors.

Table 2 - *Anti-Social Behaviour & Inexcusable/Intentional Violence & Aggression*⁸

Anti-Social Behaviour & Inexcusable Intentional Violence & Aggression				
	2014/15	2015/16	2016/17	2017/18
First quarter: Apr, May, Jun	30	34	33	29
Second quarter: Jul, Aug, Sep	38	24	20	23
Third quarter: Oct, Nov, Dec	21	34	27	42
Fourth quarter: Jan, Feb, Mar	25	40	29	17
Total	114	132	109	111

Of the reported 111 intentional violence and aggression incidents in 2017-18, 59 occurred at the RSH and 52 occurred at PRH.

30 involved physical contact (however minor or inconsequential), of these 24 were on staff (22 of these were carried out by patients/public, 2 involved staff on staff). The other 6 were by patients or relatives (public) on the same.

None of the intentional physical assault incidents involving Trust staff during 2017-18 resulted in serious injury or triggered RIDDOR reporting to the Health & Safety Executive (HSE).

⁸ Concerning all staff, patients, visitors and contractors. Source: Datix.

There were 81 intentional *non*-physical incidents, i.e. incidents of verbal abuse, threatening or other anti-social behaviour by patients, relatives or public, 74 of these were made towards staff and the other 7 towards other patients, relatives or public.

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 (4.2 refers).

Step 2 – Enlisting the assistance of hospital security officers (Section 3.10 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 reviewed 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 reported incidents of violence and aggression by writing to those members of staff who may have been injured, harmed or significantly affected by the incident offering support through line management or occupational health and counselling services and advising of the Trust's response to incidents⁹.

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 patient¹⁰. A warning letter, signed by the Chief Executive, is sent to the perpetrator of the adverse behaviour and copied to the victim and police, advising that non-emergency treatment could be withdrawn if there are any further episodes and support for police action or civil action by the Trust¹¹. 40 SEMA alerts and 68 warning letters and/or letters of concern were issued during the reporting period. Only two of those receiving our initial warning letter during the period have been reported as being involved in further incident. These two persons had their situations escalated with police.

The Trust supports all police and Court actions when taken and every effort is made to enable partnership working and achieve rightful sanction and redress for unacceptable behaviour. This often includes provision of supporting CCTV, Body Worn Video (BWV) recordings or other documentary evidence. The following are some (but not all) examples of collaborative working

⁹ During the reporting period 217 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 some way the disparity between numbers of support letters issued to Trust/NHS staff and all reported incidents (Tables 2 and 3 refer).

¹⁰ 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; 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 sanctioned.

¹¹ It should be noted that it is not always possible or appropriate to issue a warning regarding unacceptable behaviour because the individual may not have been identified or the circumstances of the individual deem it inappropriate.

with police and/or final outcomes to incidents of aggressive and/or anti-social behaviour which resulted in police or Court action during 2017-18¹²:

- A home visit was made by the Trust Security Manager and police to an address in Shrewsbury to serve an NHS Acknowledgement of Responsibilities Agreement (ARA) on a male patient whose behaviour whilst in RSH A&E and CDU during April and May 2017 caused significant concern. In each instance staff (victims) felt it either unnecessary or unable to personally complain to police about what took place¹³ but expressed satisfaction for the Trust to take action on their behalf with police. The patients activities are summarised herewith:

April 2017: Hit a female nurse (no lasting harm or injury incurred);

April 2017: Female nurse touched inappropriately;

May 2017: Racist comments made to a male nurse;

May 2017: Further verbal abuse and nuisance behaviour towards staff;

May 2017: Touched a female student nurse inappropriately.

Despite the ARA the patient's behaviour continued into June and July and eventually resulted in arrest for breach of a Criminal Behaviour Order (not to be drunk in a public place) instigated by police as his behaviour across the community escalated. His then failure to attend Court resulted in a warrant for his arrest, served after discharge during a subsequent A&E visit. He has since successfully engaged on a voluntary alcohol rehabilitation program and has not come to further attention or felt need to attend either hospital.

- During interview by police another male patient admitted to causing, on numerous occasions between the end of August 2017 and the end of October 2017 a "nuisance on NHS premises" at both hospital sites, as well "sending false messages and/or persistently using a public electronic communications network (namely the PRH telephone network & Switchboard) in order to cause annoyance, inconvenience or needless anxiety". At one point he made 98 call attempts in 55 minutes. For the matters outlined he was given a £190 Fixed Penalty notice¹⁴. During subsequent attendances the subject caused further issue and as a consequence was made the subject of a police Community Protection Notice in order to manage his behaviour whilst on NHS premises. Since the serving of the notice in February 2018 the patient has not come to adverse attention at either hospital.
- Following discharge on a day in August 2017 a male in-patient from the RSH was subsequently seen acting suspiciously elsewhere in the RSH building. When challenged by a male nurse he then barricaded himself in a Theatre Store Room that had been inadvertently left open/unattended. He then ransacked the store room and contents before smashing the store room window and eloping from site. He was subsequently arrested by police in Shrewsbury. In March 2018 said patient admitted 2 counts of

¹² 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 staffs feel able or willing to make such.

¹³ Therein negating possibility of criminal prosecution.

¹⁴ Notwithstanding the outcome the offence itself was/is a recordable offence. A recordable offence is one for which the police are required to keep a record.

Criminal Damage to Telford Magistrates. He was given a 6 month conditional discharge¹⁵ and ordered to pay £200 compensation to the Trust and a £20 victim surcharge¹⁶.

- A patient, having submitted a guilty plea, was found guilty at Telford Magistrates on 29 October 2017 of Criminal Damage. His aggressive behaviour in the PRH A&E waiting room during the early hours of 11 August 2017 resulted in a glazed window panel on the external waiting room door being kicked in and smashed. He was ordered to pay costs of £135; was given a 12 Community Order (to include 20 days rehabilitation doing a directed activity and participation in a 6 month alcohol detoxification program) and pay an £85 victim surcharge.
- Following a disturbance on 9 December 2017 in the PRH A&E department, a male patient was arrested for a Public Order Offence. He pleaded guilty at Telford Magistrates Court on 11 December 2017 to the offence of intending to cause harassment, alarm or distress through use of threatening, abusive or insulting words or behaviour, or disorderly behaviour. As a consequence he was sentenced to **8 weeks** imprisonment starting immediately and ordered to pay a £115 victim surcharge.

The number of reported incidents of intentional violence and aggression reported and recorded on Datix between 1 April 2017 and 31 March 2018 (111 incidents) is 58% less than reported between 1 April 2009 and 31 March 2010 (265 incidents)¹⁷.

At the same time positive (lower the better) results for Key Findings (KF) 22¹⁸ & KF25¹⁹ were noted for the Trust in the 2017 NHS Staff Survey with these two KF showing the largest local changes since the 2016 survey with a 5% reduction for KF22 and 2% reduction for KF25²⁰. By comparison with all Acute Trusts the results for both KF22 & and KF25 place the Trust as being below (better than) average during 2017²¹.

Whilst the progress on managing anti-social behaviour / intentional violence and aggression during this reporting period and recorded decreases by comparison with previous years 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 it is in a strong position to control and reduce its impact and severity and seek sanction or redress.

¹⁵ A conditional discharge means that the offender is released but the offence is placed on their criminal record, at the same time the Court have the power to review sentencing for the offence if the offender commits any further offence within a time period set by them (in this case 6 months). If the offender does commit a further offence within that time period, they may be recalled and resentenced for the original matter as well as the new matter.

¹⁶ When a Court passes a sentence it must also order that the relevant surcharge is paid. The amount of the surcharge depends on the sentence and whether at the time the offence was committed the offender was an adult or under 18 years of age or if the offender was an organisation. Revenue raised from the Victim Surcharge is used to fund victim services through the Victim and Witness General Fund.

¹⁷ Datix shows that a significant number of incidents reports are not submitted by staff but are none the less reported by security staff who have been called to scene to assist/deal with matters. These security staff reports are then entered onto Datix. Submission of reports by security staff is closely monitored as a monthly contract KPI. Aside from showing good staff awareness on when and how to access security support in an emergency or escalating situations this process also means that busy nursing and medical staff can focus on core business tasks and leave incident reporting on what are often very bespoke matters to security staff, whose reports by virtue of their role and contract requirements can be more detailed and consistent in terms of content. It is also a valuable safety net in terms of countering the possibility of the Trust not being sighted on everything taking place on the shop floor if staff feel they are under too much work load and/or time constraints to complete incident reporting on security matters.

¹⁸ Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months.

¹⁹ Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.

²⁰ 2017 National NHS Staff Survey: Results from The Shrewsbury & Telford Hospital NHS Trust; Section 3.2 p8.

²¹ 2017 National NHS Staff Survey: Results from The Shrewsbury & Telford Hospital NHS Trust; Section 3.4 p15.

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 & Aggression²².

CLINICAL VIOLENCE & AGGRESSION	Year			
	2014/15	2015/16	2016/17	2017/18
First quarter: Apr, May, Jun	62	75	54	77
Second quarter: Jul, Aug, Sep	78	84	79	83
Third quarter: Oct, Nov, Dec	56	84	80	65
Fourth quarter: Jan, Feb, Mar	102	86	70	85
Total	298	329	283	310

Of the reported 310 non-intentional clinical aggression incidents in 2017-18, 201 occurred at the RSH, 108 occurred at PRH and 1 off-site, but involved staff. 184 involved physical contact, 162 of these involved staff. 3 of these non-intentional physical assault incidents triggered RIDDOR reporting to the Health & Safety Executive (HSE)²³.

Notwithstanding continued rises in patient numbers, training for security staff in De-Escalation and (Physical) Management Intervention (DMI)²⁴ allied to continued availability of Conflict Resolution Training (CRT) for all hospital staff (4.2 refers) is still having a positive impact. The number of reported clinical aggression incidents *resulting in physical contact and/or injury to staff* is showing a 13% decline between the start of 2014/15 end of 2016/17 and a 6.6% decline between 2014/15 and 2017/18 (Table 3b refers). The upward spike in figures in the final quarter of this reporting year reflects a very difficult and intense winter operating period.

Table 3b - Non-intentional / Clinical Physical Aggression

CLINICAL VIOLENCE & AGGRESSION – PHYSICAL	Year			
	2014/15	2015/16	2016/17	2017/18
First quarter: Apr, May, Jun	45	55	28	47
Second quarter: Jul, Aug, Sep	47	41	50	49
Third quarter: Oct, Nov, Dec	31	36	56	35
Fourth quarter: Jan, Feb, Mar	74	43	37	53
Running Total	197	175	171	184

Evidence of increasing staff awareness on the revised policy, and confidence in security teams to provide appropriate support, is shown by virtue of recorded figures that show security staff across both sites carried out 182 safe hold of patients during the reporting year. Not all 'safe

²² Concerning all staff patients, visitors and contractors. Source: Datix.

²³ Datix id: 149532, 141666 and 139540.

²⁴ 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 Foundation Trust (SSSFT).

holds' were undertaken as a result of 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 for them and/or staff involved in the process of 'returning the patient'.

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

CLINICAL VIOLENCE & AGGRESSION - NON PHYSICAL	Year			
	2014/15	2015/16	2016/17	2017/18
First quarter: Apr, May, Jun	16	19	26	30
Second quarter: Jul, Aug, Sep	29	34	29	34
Third quarter: Oct, Nov, Dec	25	41	24	30
Fourth quarter: Jan, Feb, Mar	32	41	33	32
Running Total	102	135	112	126

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. Concomitant pressures on providers of community care, often results in unwelcome and pro-longed stays in the acute hospital setting for patients who would be better served with 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 in the form of an identity badge holder worn around the neck or clipped to a belt or tunic. It includes a panic alarm that can be discreetly activated and which automatically opens a line of communication (via roaming mobile phone signal) to a national Alarm Receiving Centre (ARC), thereby allowing situation assessment and immediate response, as well as recording of evidence. Response to alarm activation can include an emergency police response as the ARC is linked to all local police operations rooms. ARC staff are able to directly feed live information from the staff member's 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 local 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.



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.

The Trust supports 280 staff who work in the community with provision of a lone worker device. A security management work program, to transfer and give staff access to the latest series 8 device was undertaken in the reporting period. Series 8 devices are predominantly shared by staff so as to avoid the need for individual issue as staff are not off site every day or even every week. This flexibility allows for support to staff and is cost effective²⁵. To date, 184 staff have been trained in the use of series 8 devices and the potential threats from Lone Working. At the time of writing 96 staff are scheduled in coming weeks/months for training and device issue or are undergoing enabling administration to receive training and device issue.

(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.



²⁵ Any member of staff requesting a personal issue device for their sole use will be allocated one.

3.6 *Baby Tagging*

This facility is in operation at the Shropshire Women and Children's Centre at the PRH on the Post-Natal Ward and Ante-Natal Wards (standby facility should post-natal overspill). It is also installed on our Wrekin Maternity Midwife Led Unit (MLU) at the PRH and the RSH MLU. Each new born has a tag fitted after delivery. Should the infant then be taken towards a doorway, including a fire exit, the tag will alarm and send doors into Lock Down mode whilst alerting staff at the nurse base via a PC type console so they can investigate. If the Tag is forcibly removed or cut the system automatically goes into alarm. Equally the system will alarm if it detects an inability to communicate with a tag e.g. if the infant were wrapped in coverings or placed in a bag to enable unauthorised removal.

The Wrekin Maternity Unit system was installed in April 2017 after kind donation by the Friends of PRH. In December 2017 we upgraded the desktop console on the RSH MLU system to provide touch screen technology for arming and disarming of tags.



As part of our security management assurance program checks and testing of the system and staff reactions is carried out every 3 months by Ward Managers and the Trust Security Manager with feedback provided to senior management on the outcome from each test.

3.7 *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 prove 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 and this includes the new build Urgent Care Centre at the PRH, the Learning Centre at the RSH (to support 24/7 use of the facility by students and evening teaching sessions) and re-organising of existing assets to facilitate coverage of refurbished and/or re-organised areas of each hospital.

The output from cameras on our main hospital sites 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 from an approved contractor. Opportunity was taken during the reporting year at both sites to replace some of our oldest recording unit equipment which, whilst still functioning, had none the less more than passed its intended useful working life. These replacement systems offer much improved clarity for both live and played back/recorded footage as well as increased functionality.

Additional CCTV was also installed in the reception area of our Therapy Services building which is located off site at the multi occupancy William Farr House NHS site in the Copthorne district of Shrewsbury. This followed concern and risk assessment after a reported incident.

We also ensured CCTV installation is being included at off-site car parking sites in both Shrewsbury & Telford which will be used to park lease hire vehicles. Whilst these car parks are owned and operated by other organisations these systems will be fully configured, controlled and maintained in accordance with our own existing CCTV operating policy. Whilst primarily installed as a crime prevention measure and for staff reassurance, it will also be possible for recorded footage to be down loaded for play back scrutiny and preservation as and when required without need to involve third parties or access their premises.

3.8 *Access Control*

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 at both sites. Notwithstanding this, it is being included in capital refurbishment and new build projects, the latest of which is the final phase of the move of Ophthalmology Services and the re-location of ICAT into Ward 20 of the Copthorne Building at the RSH which will see the reconfiguration of existing access control arrangements in the building as well as new control points.

3.9 *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 hospital sites. To this end they were the October 2017 winners of the Trust VIP awards. The award (presented in March 2018) was given following nomination for security team work with 2 particular types of patient; adolescents in personal crisis/deemed to be at risk of significant self-harm and also in-patients undertaking alcohol detoxification treatment. More details on their nomination and support for that award are at Appendix 1.

When the Trust's manned security guarding contract expired on 1st December 2017 (after the Provider served notice on Year 3 of a rolling two year contract) Procurement staff oversaw a re-tender process 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 an EU compliant tendering process, therefore removing the need for the Trust to engage in complex and lengthy EU procurement processes. Seven security suppliers had been previously awarded onto the Framework; two of these²⁶ issued a submission for our contract to run from 1 March 2018 for 2 years. Quality and financial submissions by each supplier were evaluated and scored on 25 January 2018 by the Trust Security Manager/LSMS with colleagues from Procurement and 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%

²⁶ MITIE (Total Security Management) & Corps Security.

The evaluation process identified that MITIE (Total Security Management) were best placed to provide the Trust with manned guarding services through award of a 2 year contract. On 1st April 2016 the government introduced a mandatory National Living Wage (NLW) for workers aged 25 and above with the target of the total wage reaching £9 p/h by 2020. Hourly pay rates in the new contract reflect increases and the step towards the 2020 £9 p/h target. 12 existing core team security staff from both hospitals were transferred to the new contract under TUPE.

3.10 *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 officers²⁷. They are supported by a list of 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.

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. 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 (4.1 refers) is delivered to security teams by accredited NHS training staff from South Staffordshire & Shropshire Foundation Trust (SSSFT). There is evidence from incident reporting that suggests introduction of this training, along with a revised policy of safe handling of clinically aggressive patients²⁸ has resulted in reductions in the number of staff being harmed or injured through physical contact with clinically aggressive patients (3.4 refers).

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.

²⁷ All licensed by Security Industry Association (SIA) for Door Steward & Public Surveillance CCTV Monitoring.

²⁸ Policy for Clinical & Safe Holding of Adults and Children Receiving Care in the Trust.

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:

- Help with searching for 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)²⁹;
- Fire alarm activations and other fire incident related activity (fire safety incidents)³⁰;
- 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)³¹.

Additional security staffing was also put in place on key dates during the Christmas and New Year periods.

Additional staff presence in the form of 'stewards' has been provided at Trust Board meetings which were either designated as public meetings or which had a period allocated for public attendance/scrutiny.

3.11 *BWV (Body Worn Video) Equipment*

BWV surveillance equipment incorporating both image and audio recording was introduced in 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.

²⁹ 241 recorded occurrences in the reporting period of security staff doing this.

³⁰ 75 recorded occurrences in the reporting period of security staff of doing this.

³¹ Mon-Fri for patient valuables collection from hospital safes and thrice weekly for emptying/replenishment of car park change machines.

4 Communication, Awareness & Training

Efforts continue to raise staff awareness on security matters and encourage a proactive security culture. When appropriate, global e-mail alerts as well as screen messages can be sent out to all IT account users in the Trust. In the last year this specific type of activity has increased in response to increased threats and actual Cyber Security matters and incidents. Regular updates are sent out to staff on security improvements through Trust communication channels.

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

With non-intentional/clinical aggression security staff provide patient safe handling assistance and support to medical and nursing staff to ensure no harm comes to either patients or staff from patients who may becoming physically aggressive or challenging through no fault of their own. 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 Healthcare NHS Foundation Trust (SSSFT).

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 SSSFT 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 11 of our core team of 13 security staff undertook annual refresher training whilst 2 new staff completed the 5 day foundation course.

4.2 *Conflict Resolution Training (CRT)*

Learning & Development colleagues provide CRT for staff using the NHS Protect national approved syllabus. CRT was delivered to:

982 frontline staff via 3 hour face to face sessions and 437 other staff via e-learning³²; 108³³ junior medical staff via e-learning induction.

In addition to CRT, 40 clinical staff were provided with additional training which focuses on skills for managing challenging behaviour. Based on guidance previously released by NHS Protect and endorsed by numerous national bodies involved in or responsible for care of such patients³⁴ training is delivered by medical consultant staff from CCG RAID Teams³⁵.

4.3 *Lone Workers*

During the reporting period 107 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

³² Figures from Learning Development 6 Apr 2018.

³³ Of 192.

³⁴ Meeting needs & reducing stress (NHS Protect 2015).

³⁵ Funded through existing financial provision within the NHS Standard Contract between the Trust and its CCG's.

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.

4.4 *Corporate Induction*

During the period, 755 staff members were given security and fraud awareness briefings and training at Corporate Induction by the Trust Security Manager³⁶.

4.5 *Mask Fit Testing*

Our security contract supervisor is a trained mask fit tester and ensures 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. During the reporting period 2 new security staff were mask fit tested.

4.6 *Public Space CCTV Surveillance Training*

All of our security staff are licensed and trained in accordance with Security Industry Act requirements for use of CCTV equipment. During the period 2 new officers undertook and successfully completed this training.

³⁶ Figures from Learning Development 6 Apr 2018.

5 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:

- Stand by to support and guide the Trust on future security specifications, architecture and environment as it enters a phase of re-organisation and re-development of both hospitals as concluding decisions regarding Future Fit and Sustainable Services Program (SSP) are reached.
- 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.

Appendix 1 – Extract From Security Team VIP Award Nomination

Security teams spend much time managing anti-social behaviour from irresponsible elements of the community. However, another important albeit less well known aspect of their work is assisting in keeping young adolescent patients in A&E and preventing them self-harming whilst they await Child & Adolescent Mental Health Service (CAMHS) or other assessment. They also help reduce the risk of harm or injury to staff from clinically aggressive detoxification patients with safe handling interventions. Detoxification treatment can produce unpredictable and often explosive reactions from patients during the first few days of treatment. 'Waits' for CAMHS teams to attend site, evaluate and arrange next treatment for young patients can be very long, over 12 hours is not uncommon. Often in crisis, breakdown, or suffering from abuse or overdose, these young patients can find a wait for assessment in the busy charged atmosphere of A&E, with crowded waiting/treatment areas, frightening and traumatic. The adverse behaviour of other poorly, hysterical or misbehaved adult patients also has to be contended with. Many will try to leave before assessment.

All of this leaves security staff with the unenviable task of keeping patients with the described backgrounds in hospital, calm, reassured and updated as well as de-escalating unacceptably aggressive and sometimes violent behaviour. Dealing with provocation, taunting or threatening behaviour is par for the course. Seeing a safe and unprejudiced outcome is always the aim and to this end security team support is regularly being recognised and highlighted. Find herewith summarised feedback correspondence from colleagues to this effect.

From CAMHS Staff: Paul and Brett were very helpful to a young person in A&E. They acted in a professional supportive manner showing a great deal of understanding towards this distressed young person. Their help in de-escalating the situation was very valuable. They showed not only duty of care but also an understanding of distress to young people that was invaluable.

From NHS Choices message/feedback box: I would like to thank the (PRH) security staff on duty on Saturday, they helped me with my son so much, they really did go above and beyond, you're lucky to have them.

Ward Manager: I needed to emergency call security for a gentleman struggling with alcohol detox twice in 24 hours. Tom went above and beyond what is required of him. After the gentleman was finally settled Tom made him a drink and got him a newspaper from his own money refusing reimbursement. Tom came across as very caring in this very difficult situation.

Operations Manager: All your staff, as always, have gone above and beyond today but I wanted to single out Andy especially as he made such a difference to one particular patient who he was tasked with watching. This young lady was vulnerable and highly troubled. He built up a rapport and trust with the patient that not only made her calmer, but enabled her to get into the ambulance (whilst holding his hand) minimizing her stress. I think (her) time in the department could have been very different if he hadn't been involved.