Southern Health
NHS Foundation Trust

SH NCP 21

Security and Management of Violence and Aggression Policy

To be read in conjunction with:
Security Management Procedures
Managing Violence & Aggression Procedures
Lone Working Procedures

Version: 4

Summary:	Creating and maintaining a safe and secure environment for the staff it employs, the health and safety of the service users; that is patients, visitors, contractors and all persons who visit Trust premises or premises on which the Trust operates. Tackling violence and aggression and protecting lone workers.	
Keywords (minimum of 5):	Security; safety; crime reduction, asset protection, risk assessment; lone working; violence and aggression.	
Target Audience:	All staff employed by Southern Health NHS Foundation Trust. Non-Executive Directors, Volunteers, Governors and Contractors.	
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Version Control

Change Record

Date	Author	Version	Page	Reason for Change
May 2012	Jan Macavoy	1st Draft		New SHFT policy.
20.8.12	Jan Macavoy	1.00	6	Additional comment re equality & diversity
			10	Manager's responsibility re E&D reporting
			17	Identification of training in relation to E, D & Human Rights issues.
			18	E, D & Human Rights issues in relation to Investigations
			22/23	Inclusion of a Local Security Induction Check List
July 2015	Louise Hartland	1	25	Updated TNA (Appendix 2)
Sept/Dec 2015	Jan Macavoy	2	All	To reflect current procedures and references.
Jan 2017	Jan Macavoy	3		Change of police reporting form and process; include potential to seek reimbursement for cost of damage caused by deliberate aggressive behaviour. Reference to TQ21 has been removed.
26/2/18	Louise Hartland	3	30	Updated TNA (Appendix 2), updated contents page
24/4/18	Louise Hartland	4		Updated TNA – appendix 3&4 removed & replaced with new TNA (appendix 3) EqIA now appendix 4
18/4/19	Jan Macavoy	4	20/21	Out of date references/links removed

Reviewers/contributors

Name	Position	Version Reviewed & Date
MOVA Committee members		Draft
Louise Hartland	Strategic Education Lead – Deputy Head of Personal Development	Draft
Jonathan Beebee, RNLD	Team Leader, Southampton Intensive Support Team	Draft – 21 June 2012
John Micklewright/Brendan Harper	Local Counter Fraud Specialists	Draft 29 June 2012
Ricky Somal	Equality & Diversity Lead	Final 20 July 2012
Safer Forum; H&S Forum		

Contents

Security and Management of Violence and Aggression Policy

1. Introduction

1.1 Under the Health and Safety at Work Act 1974, Southern Health NHS Foundation Trust (SHFT) has a statutory obligation to ensure as is reasonably practicable, a safe and secure environment for the staff it employs, the health and safety of the service users, that is patients, visitors, contractors and all persons who visit Trust premises or premises on which the Trust operates.

1.2 The NHS Standard Commissioning Contract requires all providers to demonstrate compliance to the NHS Protect Standards for Providers. These standards specifically include measures which are designed to protect and make best use of assets and property and also how an organisation takes steps to protect its staff and patients from the effects of violence and aggression.

1.3 The Board of Directors at Southern Health NHS Foundation Trust is committed to a strategy to eliminate, minimise and control the risk of violence and aggression and provide a safe and secure environment to its patients, staff and visitors. Violent or abusive behaviour will not be tolerated and decisive action will be taken to protect individuals. Some acts of aggression and violence may be part of a patients' illness or condition and in such cases allowances must be made; however, where this is not the case, everyone has a duty to behave in an acceptable and appropriate manner. Staff members have a right to work, just as patients have a right to be treated, in an environment that is properly safe and secure.

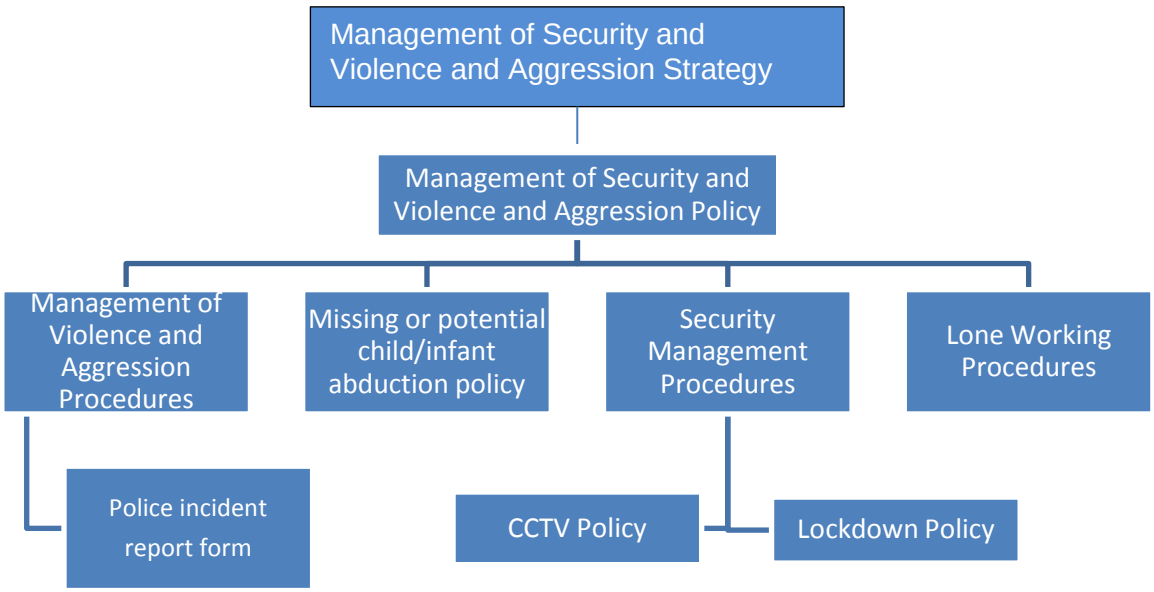
1.4 The purpose of this policy is to define roles and responsibilities for the effective management of security in relation to staff, patients/clients, visitors and property. It provides guidance that should be followed to promote secure and safe trust properties and premises; the management of violence and aggression and the safety of lone workers and to enable the trust to develop both proactive and reactive response in relation to NHS Security Management.

1.5 The trust is committed to providing the most reasonable and practicable means of:

- Providing a safe and secure environment for staff, patients and visitors to the trust's properties including the forensic and secure units it operates.
- Protecting life, or preventing bodily injury from malicious criminal activity or self-harm.
- Preventing loss of trust assets as a result of crime.
- Preserving good order on premises under the trust's control.
- Tackling violence and aggression directed at NHS staff, professionals, staff working on behalf of the NHS and those who use the trust's services.
- Protecting those who are lone-working.
- Seeking compensation or recompense from losses caused by deliberate acts of aggression and violence.

1.6 SHFT recognises that, as an employer, it has a duty of care towards its staff and will take necessary and reasonable steps to ensure their health and safety at all times. It is also acknowledged that all employees have a responsibility for the safety of themselves, their colleagues, patients and service users. Specific procedures applicable to local needs will be developed and implemented within an agreed timescale in consultation with Directors and Staff representatives to address local issues.

1.7 SHFT is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as an employer. The Trust believes that all people have the right to be treated with dignity and respect and is committed to, the elimination of unfair and unlawful discriminatory practices.



The above diagram sets out the organisational policies and procedural documents to support the management of security and violence and aggression.

2. Scope

2.1 **Inclusions** – This policy relates to employees of SHFT and staff working on behalf of the trust or within trust property, or property that is leased to the trust, or by the trust.

This policy covers all employees within the trust and will supersede all other relevant policies under previous terms and conditions of employment held by individuals who have transferred into the trust from other NHS organisations.

2.2 **Exclusions** – There are no persons or areas of the Trust premises excluded from the principles of this policy.

3. Definitions

3.1 The following abbreviations, definitions and terms are used throughout this policy.

CAS – Central Alerting System
CBRN – Chemical, Biological, Radioactive, Nuclear (usually used to describe particular types of attack or prevention from attack).
CCTV – Closed Circuit Television
CISM – Critical Incident Stress Management Team
CRT – Conflict Resolution Training
HSSA/WPAs – Workplace Health, Safety and Security Assessments
LSMS –Local Security Management Specialist

LCFS – Local Counter Fraud Specialist
MHA COP – Mental Health Act Code of Practice
NICE – National Institute for Clinical Excellence
SHFT – Southern Health NHS Foundation Trust
SIRS – Security Incident Reporting System (NHS Protect)
SMD – Security Management Director

3.2 **Aggression –** A disposition, willingness to inflict harm, regardless of whether this is behaviourally or verbally expressed and regardless of whether physical harm is sustained. *(NICE guidelines 25, 2005)*

3.3 **Violence –** The use of physical force that is intended to hurt or injure another person. *(NICE guidelines 25, 2005)*

3.4 **Lone Working –** NHS Protect defines lone working as: any situation or location in which someone works without a colleague nearby; or when someone is working out of sight or earshot of another colleague.

The Health and Safety Executive (HSE) defines lone workers as: those who work by themselves without close or direct supervision.

4. Duties / Responsibilities

4.1 Chief Executive

The Chief Executive has ultimate responsibility for the management of security and safety. This responsibility includes ensuring the aims and objectives of this policy are met, and ensuring that adequate resources are made available.

4.2 Board of Directors

The Board of Directors have the responsibility of setting the strategic direction of the Trust and overseeing the implementation of policies and objectives including those relating to security management. It is the Board of Directors' responsibility for decision-making on the management of all types of security risks within this organisation including:

- Ensuring that the aims and objectives of this policy and associated procedures are met.
- Ensuring that adequate resources are made available.
- Ensuring that arrangements are in place for the effective management of security and safety issues.
- Ensuring that any systems in place for the management of security, violence and aggression and lone working are reviewed by managers and the Board.
- Ensuring the effectiveness of the key personnel listed below in undertaking their security management responsibilities is reviewed as part of the policy review process and the LSMS is satisfied that undertaking of specified duties is being undertaken globally or any failures to undertake the duties reported to the relevant line manager for action.

However, certain Executive and Non-Executive Director(s) have a specific role in the strategic management of security based on the specific Directions from the Secretary of State for Health these are specified below.

4.3 The Director of Finance

The Director of Finance is the nominated Executive Security Management Director (SMD) with special responsibility for security management and will lead in promoting a pro-security culture; the safety of lone workers and tackling violence against staff.

4.4 Non-Executive Director

An identified Non-Executive Director has been nominated to support the lead Executive Director and to act as scrutineer of the Annual Report and Trust Wide Annual Risk Assessment.

4.5 Senior Health, Safety and Security Manager

The LSMS will liaise with the Senior Health, Safety and Security Manager over issues that arise from security related incidents. By exception any on-going risks will be escalated to the Health and Safety Forum and where appropriate will be added to the Corporate/Divisional Risk Register and included and managed as part of the Risk Management Strategy. Incidents relating to violence and aggression will be escalated to the Safer Forum.

4.6 Associate Directors/Heads of Service/Departments & Matrons/Specialty Managers

Associate Directors/Heads of Service/Departments & Matrons/Specialty Managers are accountable for ensuring that:

- All managers are aware of their responsibility to participate in risk assessments in conjunction with the LSMS in their area of managerial control, and that those assessments take into account security risk relating to physical security of premises and assets and that environmental issues that may act as triggers to violence and/or aggression are taken into consideration. This will include role risk assessments for staff working on or off site or in the community or in other premises not owned by SHFT. See Workplace Health, Safety and Security Audit Guidance and Role Risk Assessment Guidance.
- The principles of “least restrictive practices” are balanced against our duty to provide a safe and secure environment.
- Ensuring that action is taken as a result of risk assessments.
- Local procedures/contingency plans are drawn up in consultation with affected staff, or their representatives to deal with both foreseeable events and other emergencies, for example security and locking up procedures or containment for radioactive material.
- Action is taken to protect staff from the effects of violence and aggression; appropriate support is provided following incidents.
- Ensuring that appropriate Lockdown Risk Profile Assessments have been carried out to establish the vulnerability of the department/area and the necessity and ability to carry out a lockdown, either; full, partial or progressive, which will be fed into the trust wide Lockdown Plan.
- Any training needs identified as a result of risk assessments are actioned appropriately.
- The effectiveness of the undertaking these duties will be monitored and documented as part of the trust appraisal process.
- Where appropriate compensation or recompense following acts of deliberate damage and aggression.

4.7 **Local Security Management Specialist (LSMS)**

The **Local Security Management Specialist (LSMS)** will be accredited by completion of NHS Protect Foundation Level Training. The LSMS is responsible for creating and developing a pro-security culture and working environment by working with managers and attendance at Safer Forum; Health & Safety Forum and Emergency Planning and Resilience Forum to ensure that a holistic approach to security management is followed to ensure:

- All incident reports are reviewed and actioned appropriately, trend analysis is conducted and shared across the organisation to reduce the likelihood of further incidents and that a pro-active approach is taken with regards to security, safety of staff and the management of violence and aggression.
- Supporting managers and teams in claiming compensation or recompense following deliberate acts of aggression or violence.
- Reports are created and uploaded to the NHS Protect Security Incident Reports System (SIRS)
- Trend data is monitored to ensure that lessons learned and best practices are shared across the wider organisation.
- Close working relationships are developed with the Head of Crown Prosecution Service and Senior Police Officers to ensure action is taken where prosecution is appropriate.
- Liaison with neighbouring LSMS to agree a consistent approach to the tackling of violence and aggression across NHS sites.
- Provision of reactive support in the event of any incident (i.e. reporting assaults to the Police):
  - Liaise with the police in relation to incidents of violence to ensure appropriate sanctions where appropriate is achieved and that assaults and security incidents such as criminal damage or vandalism are investigated.
  - Ensuring that following any incident of violence or aggression, risk assessments have been conducted to establish any actions with regards to the aggressor are taken, for example a letter explaining the Trust position on violence and aggression to staff.
- A comprehensive approach is adopted over the maintenance of trust property.
- Liaison with the Learning and Development LEaD Team for the provision of Induction Training and training that relates to managing violence and aggression.
- Liaison with Local Security Management Specialists from other NHS Trusts within Hampshire and neighbouring counties
- Ensuring that local and national alerts and warnings are disseminated via the Trust Central Alerting System (CAS).

Working within a professional and ethical framework and at all times meeting the six core principles; *professionalism; objectivity; fairness; expertise, propriety and vision:*

- Carrying out security reviews of the Trust's properties, identifying potential problems and assessing any risks that may arise. Including the associated environmental risks that can act as triggers for violent or abusive behaviour.
- Providing advice and guidance to Managers and staff over security issues.
- Developing a strategy and action plan to tackle problems and deliver improvements across the wider trust.
- Ensuring that appropriate risk assessments have been carried out to establish the vulnerability of a department/area and the necessity and ability to carry out a lockdown, either; full, partial or progressive, which will be fed into the trust wide Lockdown Plan. Utilising Department of Health Project Argus and Project Artemis materials to raise awareness of lockdown procedures. Ensuring that the Lockdown plans are in place and tested for efficacy.

- Ensuring that all events that lead to a lockdown, either, full, partial or progressive are reported through the Risk Management Strategy. The LSMS will lead on the review of the incident to capture all lessons learnt and included as part of the LSMS Annual Report and quarterly reports. Any risks identified will be added to the LSMS Annual Work Plan and actions taken to mitigate those risks monitored in line with the organisation Risk Management Strategy and Policy. Where appropriate, identified risks will be added to the Corporate Risk Register.
- Using expertise to ensure that identified risks are escalated and the implications of such risks considered trust wide to provide an organisational overview. Issues will be referred to the Senior Health, Safety and Security Manager and where appropriate added to the Risk Register.
- Producing an Annual Security Management Report for the Board. The specific areas of work for the LSMS are tackling violence and aggression; protecting property and assets; security of drugs, prescription forms and hazardous material; and protecting maternity and paediatric departments. The report will cover work undertaken in these areas, including actions taken in creating a pro-security culture, deterrence, prevention, detection, incident investigation, sanctions and redress. An update will be provided quarterly.
- Following Board ratification, ensuring that the LSMS Annual Report is available for review by commissioning organisations in line with the Standard Commissioning Contract for Providers.
- Leading on national and local initiatives.
- Leading on the completion and submission of the NHS Protect Self Review Tool in relation to the organisation's compliance against set standards relating to:
    - Strategic governance
    - Inform and involve
    - Prevent and deter
    - Hold to account
- The effectiveness of the Local Security Management Specialist in undertaking these duties will be monitored and documented as part of the trust appraisal process.

4.8 **Line Managers**

Line managers are responsible for:

- Ensuring that appropriate risk assessments have been carried out to establish the vulnerability of the department with regards to security and of staff coming into contact with patients who may pose a risk of violence and aggression. See Health, Safety and Security Workplace Audits
- Reporting security incidents or breaches (i.e. criminal damage, violence and/or aggression, theft or break in) to the Police in the first instance and/or Local Security Manager (LSMS) in accordance with the Incident Reporting Policy and ensuring that all such incidents are graded for seriousness and investigated accordingly, using the outcome of investigations to update risk assessments and action plans in accordance with the Risk Management Strategy and ensuring that action is taken. Where an assault has been reported to the Police the relevant documentation has been completed to support the police in taking action if appropriate. **[Appendix 2]** Ensuring that compensation or recompense is claimed following acts of deliberate aggression or violence.
- Ensuring that local procedures are in place and documented for the locking up and security of the site or department and that all staff are familiar with the trust and/or local procedures that have been adopted for the security of staff, patients and NHS property and that staff in their area are made aware of any risks and consulted on measures to be introduced to minimise them prior to them being put in place. **(Appendix 1 – Local Induction Security Check List)**

- Ensuring that premises security does not compromise the safety of staff, patients, visitors or others and that, incidents or near misses are escalated and actions taken as appropriate.
- Any training needs identified as a result of risk assessments or incidents are actioned appropriately.
- In-patients units conduct regular reviews of patient's behaviour and include relevant risk assessments and control measures and that these are documented shared with all staff to promote safer working practices whilst at the same time keeping in mind the requirements of "least restrictive practice".
- Ensuring that where control measures have been taken to manage a patient's behaviour, that the affected patient has been offered the opportunity and encouraged to submit a report detailing their perception of the incident, their view of possible contributory factors and their feelings as a result of the actions.
- Reviewing patient's reports following an incident where control measures have been applied to establish learning and best practices.
- Providing effective communication and support to those who may face violence and aggression and ensuring lone worker procedures and protocols are in place and followed.
- Ensuring that, following an assault [physical or any non-physical incident including discrimination, harassment or abuse, etc.] or incident of criminal damage or theft; support must be given to the member(s) of staff who experienced or witnessed the incident as they could be distressed or may play down the incident.
- Ensuring that staff are aware of their right to report assaults to the Police and that if an assault is not reported to the Police then the opportunity to make a claim under the Criminal Injuries Compensation Scheme, even if a conviction is not made, will be lost.
- Ensure appropriate referrals to the organisations Occupational Health provider as a result of exposure to incidents of violence and aggression. Ensuring systems and processes are in place whereby staff are supported following any incident (e.g. Union representation, prosecutions or temporary re-deployment).
- Identifying any potential prosecution or action necessary against offenders and taking forward any action deemed necessary in conjunction with LSMS and/or SMD.
- Ensuring that all their identified staff attend mandatory training for the management of violence and aggression, including Conflict Resolution Training/PRISS and that this is followed up by refresher workshops as per the Training Need Analysis and High Priority Risk Assessment.

4.9 **Employees**

All employees have responsibility to take reasonable care of their own safety and security, as well as the safety and security of others who may be affected by their acts or omissions, i.e. for the security of their colleagues and visitors. All employees are responsible for:

- Ensuring that all security recommendations or provisions that apply to the area of the trust property/area that they occupy or visit are adhered to including those that relate to lone working, where applicable.
- Ensuring that in secure or protected environments that they do not bring items that are considered contraband or restricted onto ward areas and that lockers are used to store such items.
- Ensure that they wear an appropriate identification badge when on trust premises and lead by example, such as challenging other members of staff or visitors in relation to a lack of clear identification.
- Making themselves and others aware of any potential security risks [environmental or patient related] and the measures that have been put in place to control the risk.

- Avoiding situations where they may feel, or be put, at risk.
- Reporting any security incidents or breaches to their Line Manager and/or the LSMS in accordance with the Risk Management Strategy through completion of Ulysses Safeguard reports and where appropriate reporting the incident to the Police.
- Reporting incidents of assault or discrimination immediately when they do happen, so that appropriate support can be offered by their manager and colleagues keeping in mind that *when incidents go unreported they are more likely to be repeated.*
- Following any incident where restraint has been used, encourage the patient to complete a report outlining their perception of the incident, their view of possible contributory factors and their feelings as a result of the actions.
- Attending training relating to safety and security, including training relating to managing conflict and violence. All frontline staff and staff in high risk areas will receive mandatory training and refresher training as detailed in the Training Needs Analysis.
- Staff working in premises not owned by the trust must familiarise themselves with local security controls and ensure that they are adhered to, reporting any issues to the local estates/facilities team.

4.10 **Safer Forum**

The Safer Forum will meet on a monthly basis and leads on all matters relating to the management of violence and aggression directed at NHS staff, those who work on behalf of the NHS and those who provide services to the NHS within SHFT. The forum will be chaired by Mayura Deshpande Consultant in Forensic Psychology and will:

- Develop an annual work plan to reduce violence and aggression
- Review quarterly reports on the numbers of incidents relating to violence and aggression; analyse and monitor trends, looking for possible cause and effect in order to reduce incidents
- Promote best practice across the wider organisation
- Review training plans and compliance to agreed targets
- Review issues escalated from the Health & Safety and Secure Services Forums

4.11 **Health and Safety Forum**

The Health and Safety Forum is a delegated committee of the Board with responsibility for overseeing work that relates to safety and security. It will receive quarterly exception reports that relate to security via the LSMS. The Health and Safety Forum reviews the following security related subjects:

- LSMS Annual and quarterly update.
- The annual organisation-wide security work plan
- Annual NHS Protect Self Review Tool submission [SRT]
- Annual Report of Physical Assaults [RPA]
- Departmental security risk assessments
- Security related incidents and trends
- Reports escalated from the Safer Forum.

4.12 **Occupational Health**

Occupational Health can provide guidance and support to members of staff affected by incidents, in particular those that relate to workplace violence and aggression. Referrals may be made either directly by the staff member or their line manager.

4.13 **Patients/Visitors**

All **Visitors** are responsible for guarding the safety of their own property. Southern Health NHS Foundation Trust accepts no responsibility for the loss or damage to personal property of any kind, including money, in whatever way the loss or damage may occur unless the property has been handed in to the provider for safe custody and an official receipt obtained.

4.14 **Contractors**

All contractors or staff working on or behalf of the Trust are have responsibility to take reasonable care of their own safety and security, as well as the safety and security of others who may be affected by their acts or omissions, i.e. for the security of staff, patients and visitors.

In particular when working in in-patient environments, contractors must take care of equipment, tools and supplies that may be used to cause harm or self-harm. All tools must be accounted for when leaving our premises.

5. Reporting and Management of Incidents

5.1 The Trust's Risk Management Strategy and Incident Reporting Policy must be followed with regards to the reporting and management of incidents relating to security breaches and near misses, for example where a breach has taken place but no harm done, for example a door which should be secure but is found to be unsecured so unauthorised access may have been achieved, even if there is no evidence to suspect access has taken place.

5.2 In addition to this the incidents shall be uploaded to NHS Protect Security Incident Reporting System (SIRS) by the quality and risk management team.

5.3 All incidents that are reported will be graded for severity and will input to the LSMS work plan and where appropriate escalated through the relevant forum.

5.4 The types of incident that constitute a security incident are detailed below. Incidents will be managed in accordance with the guidance set out in the following supporting documents:

- Security Management Procedures
- Managing Violence and Aggression Procedures
- Lone Working Procedures

5.5 Following review of an incident alterations or work may be required to premises in order to prevent recurrence. Works will be categorised as follows:

Level 1 Measures to be taken quickly to improve security; that have minimal expenditure e.g. publicising and adhering to existing instructions – **ACTION** to be carried out at local level**.**

Level 2 Measures required to counter an identified threat or weakness requiring resources to rectify e.g. installing a keypad door entry system – **ACTION** at local level, but may require additional resources.

Level 3 Long term measures required to improve the security of a building e.g. installation of CCTV, intruder or panic alarm system – **ACTION** at higher level of management and funding will need to be considered against other priorities.

6. Fuller Definitions of Incidents and Procedures

The following list includes types of incident that are commonly experienced within the NHS; this list is not exhaustive and there will be other types of security related incident that must be reported.

6.1 Physical assault

A physical assault is defined as *"the intentional application of force, to the person of another, without lawful justification, causing physical injury or personal discomfort". (Eisener v. Maxwell 1951, Kaye v. Robinson 1991)*

All alleged physical assaults must be reported:

- All incidents of physical assaults of staff or contractors must be reported using the Trust risk management reporting system, Safeguard in line with the Incident Reporting Policy. The Local Security Management Specialist will report them to NHS Protect via SIRS. The LSMS will assist the line manager in completing additional reports for NHS Protect where necessary.
- The **Secretary of State Directions** allow the decision of whether the police should be contacted or not, to be made locally. In reaching this decision, the following criteria must be taken into consideration:

"Following an alleged physical assault on a member of staff, the police must be contacted by the person assaulted, their line manager or relevant colleague, except in those cases where the Security Management Director, or an appropriately qualified delegate, having consulted with relevant staff and obtained clinical advice, has reached the conclusion that the assault was not intentional and that the patient did not know what he was doing, or did not know what he was doing was wrong due to the nature of his medical illness, mental ill health or severe learning disability or the medication administered to treat such a condition. The view of the person assaulted should also be sought in each incident."

However, whilst this means that there are instances where the police do not have to be called, the presence of a mental illness for example should not automatically be used as a reason not to report the assault to the police. Whilst the presence of a mental illness is one of the factors to be taken when considering a prosecution, it is not the only factor. Each case would be judged on its merit, and it is important to note that decisions on intent and subsequent legal action rest with the investigative body and ultimately, the courts, and not the Trust.

It is important to also bear in mind that the presence of a medical condition should not preclude appropriate action being taken and it is essential to ensure that there are clear risk management processes in place for dealing with high risk or mentally ill patients and that these are shared with all relevant staff. Where it is a clinician's view that the aggressor has capacity and is fit to be interviewed the Incident Form for Police, Appendix 2 should be completed and provided to the Police as soon as possible so that they are aware of all information when CPS are making decisions.

The aggrieved of the incident will be kept fully informed of the progress of any investigation or action taken and will be offered the full support of the Trust such as debriefing, counselling services or other appropriate support that would be considered necessary or desirable in the circumstances.

The incident is reported and recorded according to the requirements of NHS Protect in all cases of Physical Assault.

6.2 Non-physical assaults

A non-physical assault is defined as *"the use of inappropriate words or behaviour causing distress and/or constituting harassment". (NHS Protect)*

It is important to recognise that non-physical assaults can be just as upsetting as a physical assault and where staff members are subjected to repeated incidents of abuse this can lead to stress and sickness. Such behaviours may include, but is not limited to gesturing; using abusive language or making personalised comments; inappropriate use of pitch, pace and tone in communication; making racist or defamatory comments; invading personal space or blocking an exit.

Non-physical assaults may take place in face to face situations or over the phone; email or via social media.

Social media may be used to post messages about staff. Where postings are considered derisive and potentially abusive; or where racist comments or threats of violence are made, these may constitute an offence under:

- Section 5 of the Public Order Act 1986
- Protection from harassment Act 1997
- Section 127 of the Communications Act 2003
- Section 1 of the Malicious Communications Act 1988

Staff should report incidents offensive social media postings using Safeguard and liaise with the LSMS over whether the posting should be reported to the Police. Most social media platforms operate a Terms of Use Policy, which makes it clear that they will not tolerate 'targeted abuse' or harassment of individuals; such conduct may include:

- if the sole purpose of the account is to send abusive messages to others; or
- if the report behaviour is one sided or includes threats

Staff may report the abusive/threatening posts to the relevant social media platform, can be done directly on-line, via an offending post.

Although staff may find having a visit or consultation recorded distracting or unsettling; in the vast majority of cases, patients or visitors recording staff openly or covertly will not be committing any criminal offence. In fact there are occasions when it could be considered good practice and should be encourages.

All non-physical assaults on a member of NHS staff or professional must be reported and the details recorded in accordance with the Incident Reporting Policy. In appropriate cases, assessed by reference to their nature and seriousness, the police will be contacted as soon as reasonably practicable and full co-operation should be given to the police in any subsequent investigation. Where the aggressor is a patient or service user, Appendix 2 may also be used to confirm they have capacity to recognise the consequences of their behaviour.

As with physical assaults, the aggrieved of the incident will be kept fully informed of the progress of any investigation or action taken and will be offered the full support of the Trust such as debriefing, counselling services or other appropriate support that would be considered necessary or desirable in the circumstances.

6.3 Theft (or allegation of theft)

Theft is defined as "*To dishonestly appropriate the property of another with the intention to permanently deprive the other of it".*

All security related incidents must be reported using the Trust incident reporting process. All incidents where it is considered that a theft has taken place should be reported to the Police using the non-urgent incident reporting number 101.

i) Trust property and assets – Trust property/or assets that have been considered to have been stolen must be reported through the incident reporting process. Where the loss may impact on the delivery of services, the Estates/Facilities Manager must be advised immediately so that corrective action can be taken.

The LSMS will alert NHS Protect of all incidents that may be part of a trend or may have an impact on other NHS Trusts or providers, for example the theft of Nitrous Oxide, or activity by known members of criminal groups, for example "The Coventry Falcons".

ii) Patient's property – All staff should be familiar with the Patient Property Policy and any associated departmental instructions relating to patients' property and must ensure they are followed accordingly.

Losses of patient personal belongings should be managed in accordance with the Patient's Property Policy. The relevant manager must complete a local investigation and ensure all incidents are reported in line with the Trusts Incident Reporting Policy.

Patients and relatives should be advised and encouraged to retain minimal amounts of money and to keep valuables on their person or request that a relative or friend takes the property home for them.

Alternatively money and/or valuables can be held by the Trust in safekeeping for the patient. The Trust cannot be held liable for any valuables or money which is not handed in for safe keeping.

iii) Staff property – Losses of staff personal belongings whilst at work will be reported through the Trust incident reporting procedure. Following consultation with the LSMS the staff member or Manager will inform the Police where necessary.

Where a member of staff is suspected of the theft of either Trust or patients' property, any investigation must be conducted in accordance with SHFT Disciplinary Process and Procedures. Before searching any staff member who is suspected of theft or wrongdoing, Managers must follow the strict guidance which is set out in the Staff Stop and Search Policy

Staff are encouraged to bring the minimum amount of cash or valuables to work and to ensure that their possessions are stored in a locker or locked drawer and that when vacating any office or department that the area is secured.

6.4 Intruders/Unsecured areas

These incident types include the presence of suspicious persons on site, individuals found in an area where they have no legitimate right to be, or identifying an area or setting which should be secured but which is found to be open and/or accessible.

All staff are encouraged to challenge persons found to be in areas of the Trust where they have no legitimate right or reason to be, but only where it is deemed safe to do so. Security staff (if applicable) should be called and where appropriate the Police. All such incidents must be reported in line with the Incident Reporting Policy.

The LSMS will alert NHS Protect Area Security Management Specialist of all incidents that may be part of a trend or may have an impact on other NHS Trusts or Providers, for example activity by known members of criminal groups, for example “The Coventry Falcons”. The LSMS will also cascade alerts to staff when such groups are known to be operating in the area via CAS.

6.5 Damage to Property – Criminal Damage and Vandalism

Where there is evidence of criminal damage and the investigation identifies the offender, the Trust through the LSMS will liaise with local police to enable action to be taken through the Criminal Justice System. Redress in the form of compensation for wilful damage will also be sought in the Civil Courts, this will include instances where patients have deliberately caused damage to Trust property.

Incidents of accidental damage should also be reported and investigated to establish whether it was caused by neglect of duty or gross carelessness and identification of any lessons learned to prevent further incidents.

6.6 Fraud

The Fraud Act 2006 represents an entirely new way of investigating fraud. It is no longer necessary to prove a person has been deceived. The focus is now on the dishonest behaviour of the suspect and their intent to make a gain or cause a loss.

The offence of fraud can be committed in three ways;

- Fraud by false representation (s.2) – lying about something using any means e.g. by words or actions,
- Fraud by failing to disclose (s.3) – not saying something when you have a legal duty to do so: and
- Fraud by abuse of a position of trust (s.4) – abusing a position where there is an expectation to safeguard the financial interests of another person or organisation.

It should be noted that all offences under the Fraud Act 2006 occur where the act or omission is committed dishonestly and with intent to cause gain or loss. The gain or loss does not have to succeed, *so long as the intent is there*.

Reporting fraud or corruption – Staff who suspect any fraudulent activity, e.g. staff working in another organisation or business whilst sick, should refer this to the Local Counter Fraud Specialist in the first instance, The LCFS may be contacted for advice.

- Counter Fraud Services are provided to SHFT by tiaa. Andy Morley can be contacted on 07827 230521 or Tiaa offices on 0845 300 333 or via email Andrew.morley@tiaa.co.uk
- Alternatively contact the NHS Fraud and Corruption Reporting Line (0800 028 40 60) or the online fraud reporting form at www.reportnhsfraud.nhs.uk

7. Training requirements

Incident reporting and training needs analysis undertaken across the Trust will identify the need for different types of training for staff to reflect the specific needs of service users and the staff caring for them.

It is a mandatory requirement for *all* staff to complete Conflict Resolution Training every three years. Conflict Resolution Training is included in the more intensive prevention and management of aggression training courses provided by the Trust and therefore staff are not required to attend Conflict Resolution Training as a separate event if they are required to attend, and have attended, one of the following courses;

- Proactively Reducing Incidents for Safer Services (Adult Mental Health, Specialised Services & Learning Disability Services)
- Proactively Reducing Incidents for Safer Services (OPMH)

Proactively Reducing Incidents for Safer Services (AMH, Specialised Services & Learning Disability Services)(PRISS) is a mandatory training requirement for front-line staff working in Adult Mental Health, Specialised Services & Learning Disability inpatient units. Identified staff need to complete the 4 day programme and thereafter complete the 2 day Refresher training every 18 months.

Proactively Reducing Incidents for Safer Services (OPMH) (PRISS OPMH) is a mandatory training requirement for front-line staff working in Older Persons Mental Health inpatient units. Identified staff need to complete the 2 day programme and thereafter complete the 1 day Refresher training every 12 months.

Please refer to the Training Needs Analysis for details of the staff who require the different elements of prevention and management of violence and aggression training (**Appendix 4**)

Registered nurses who employ PRISS interventions, rapid tranquilisation and/or or seclusion should as a minimum be trained in Immediate Life Support. All other clinical staff need to be trained in Basic Life Support.

Managing Risks and Meeting Local Need - Other staff may be identified to undertake Proactively Reducing Incidents for Safer Services as part of the local clinical risk assessments and they can also access the training but this should not be classed as mandatory training.

Any Bank or Agency staff employed to work a shift will be requested to inform the nurse in charge when they last undertook the required training in the management of violence and aggression. The nurse in charge will ensure that the level of responsibility and expectation to become involved with incidents of violence and aggression during the shift will depend on their level of training and competence.

Overall security awareness training will be carried out by the LSMS by request.

8. Monitoring compliance

8.1 The effectiveness of this policy will be reviewed on an annual basis and assessed by reviewing its implementation and application across the organisation in line with the requirements of the NHSLA minimum data set for Standard 4 – Safe Environment review will be led by the LSMS and approved by the MOVA and Health & Safety Committee.

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
Workplace Health, safety	LSMS/ H&S	A sample of 3 HSSA will be	Quarterly	Non-compliance will be reported

and Security Risk Assessments [HSSA] (Target 75% compliance for completion) – Including compliance with the documented process for: ❑ completion of WPRAs ❑ how action plans are developed as a result of risk assessments ❑ how action plans are followed up		reviewed per quarter and security elements will be inspected at during site audit		through H&S Forum/Safer Forum.
Lone Worker Safety (Target 75% compliance) –Including compliance with the documented arrangements for making sure lone workers are safe, i.e. risk assessments.	LSMS	Review a sample of 3 Role Risk Assessments to ensure they have been conducted within sites/services as part of cyclical review.	Quarterly	Non-compliance will be reported through Safer Forum /H&S Forum.
Management of violence and aggression – (Target 75% compliance) – Including compliance with the documented process for: ❑ how the Organisation carries out risk assessments for the prevention and management of violence and aggression ❑ timescales for review of risk assessments ❑ how action	LSMS	Review incidents to ensure that appropriate steps have been followed.		Non-compliance will be reported through Safer Forum / H&S Forum.

plans are developed as a result of risk assessments - how action plans are followed up				
Training – achievement of training plan against target numbers of staff trained – target 75% compliance	LEaD – Safer Forum membership	LEaD database audit based on attendance register.	Quarterly	Non-compliance will be reported through H&S & Safer Forums.
LSMS Performance	Line manager	PDP	Quarterly	Line Management responsibility
Employee Duties and Responsibilities	Line manager	Staff members effectiveness in undertaking the listed duties will be monitored and documented through the appraisal process	Half yearly	Line management responsibility.

8.2 Investigations will consider whether any equality, diversity or human rights issues were part of the causes of the incident. Any incident which involves potential discrimination will be reported to the Equality and Diversity team and the Patient Experience team for review. Patients have access to complaints process if required. The data will be used to identify if there are problems in certain areas or with specific groups of people and what can be done to support patients and staff.

8.3 The process for monitoring compliance with statutory and mandatory training requirements is outlined in the Trust Learning and Development Policy.

8.4 In addition, the effectiveness of existing security measures is also monitored via other means e.g. staff surveys, NHSLA and CQC standards.

9. Policy review

9.1 This policy will be reviewed in light of any national or statutory changes by the LSMS. All new policies, operational documents will be reviewed every 3 years as a minimum.

10. Associated documents

- Risk Management Strategy
- Risk Management Policy
- Incident Reporting Policy
- Health and Safety Policy

- Policy for the Assessment and Management of Ligatures
- Information Security Policy
- Emergency Plan
- Raising Concerns/Whistle Blowing Policy
- Policy on Policies
- Information Governance Policy
- Emergency Lockdown Policy
- Patient Property Policy
- Security Management Procedures
- Management of Violence and Aggression Procedures
- Lone Worker Safety Procedures
- Staff Stop and Search policy
- Restrictive Practices Policy

11. Supporting references

In developing and documenting this policy, due account has been taken of the following source documents:

11.1 Legislation:

- Health and Safety at Work etc. Act 1974
- Management of Health and Safety at Work Regulations 1999 SI 1999/3242
- Occupiers Liability Act 1984
- Safety Representatives and Safety Committees Regulations 1977 (a)
- The Health and Safety (Consultation with Employees) Regulations 1996 (b)
- The Corporate Manslaughter and Corporate Homicide Act 2007
- The Counter Fraud and Security Management Service (Establishment and Constitution) Order 2002 SI 2002/3039
- Directions to NHS Bodies on Security Management Measures 2003 (Amendment) Directions 2006
- Criminal Justice and Immigration Act 2008 Part 8 Section 119
- Directions to Bodies on Security Management Measures 2004
- NHS Standard Commissioning Contract
- NHS Protect Standards for Providers

11.2 Websites and Reference Documents

The Health and Safety Executive (HSE) website provides further information and resources:
www.hse.gov.uk

- 'Risk Assessment for Work Related Violence'. HSE website page.
- 'Work Related Violence'. HSE website page.
- *Violence at Work: A Guide for Employers*. (2006)
- *Working alone: Health and safety guidance on the risks of lone working*. (2009)
- *Preventing workplace harassment and violence: Joint guidance implementing a European social partner agreement.* (2009)
- *A Professional Approach to Managing Security in the NHS*. (2003)
- *Foundation Level Training for Local Security Management Specialists*. (2008)
- *NHS Security Management Service security of prescription form guidance*. (2008)
- *NHS Security Management Manual*. (2008) (Restricted access to Local Security Management Specialists)

- *Concordat between the Health and safety executive and the NHS Counter Fraud & Security Management Service.* (2005)
- *A Professional Approach to Managing Security in the NHS*. (2003)
- *Conflict Resolution Training. Implementing the National syllabus*. (2004)
- *Non Physical Assault Explanatory Notes. A framework for Reporting and Dealing with non-physical Assaults against NHS Staff and Professionals*. (2004)
- *Offensive Weapons. NHS Security Management Service Guidance.* (2006)
- *Prevention and Management of Violence Where the Withdrawal of Treatment is not an option.(*2007)
- *Tackling Violence against Staff: Explanatory Notes for Reporting Procedures Introduced by Secretary of State Directions, in November 2003 (updated June 2009).* (2007)
- *NHS Security Management Manual*. (2008) (Restricted access to Local Security Management Specialists)
- *Not Alone: A Guide for the better protection of lone workers in the NHS.* (2009)
- *Department of Health.*
- *Security Management Service (NHS SMS*). (2006). *Security of NHS Car Parks – A Guidance Document*.
- Health and Safety Commission (HSC). (1997) London. HSE Books
- NHS Employers. (2010). 'Health and safety essential guide'. *NHS Employers website pages. NHS Employers. Available at: www.nhsemployers.org*
- *UNISON. Violence against staff in the NHS. Available at. https://www.unison.org.uk/at-work/health-care/key-issues/violence-staff-nhs/*
- *Department of Health. (2008). 'Code of Practice: Mental Health Act 1983'. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF*
- *National Institute for Clinical Excellence. (2005) NG10: NICE Guideline Violence and aggression: short-term management in mental health, health and community settings. Available at https://www.nice.org.uk/guidance/ng10*
- *NHS Estates. (2004) Best practice guidance: Establishing and Managing Backlog. Department of Health. Available at: https://www.gov.uk/government/publications/making-hospital-equipment-meet-the-minimum-safety-standards*
- Criminal Injuries Compensation Authority: Criminal Injuries Compensation Scheme 2008. Available at www.cica.gov.uk

APPENDIX 1

Local Induction Security Check List

For use by Line Managers to ensure all issues relating to security and safety are covered during local induction. A signed copy should be given to the member of staff and a copy held in the personnel file.

Please note this list is not exhaustive and can be adapted to include issues specific to your department/team.

		√ or N/A when complete
1	**Environment**	
	Identify physical security measures in relation to premises: • Opening and closing routines/responsibility for the office/department/clinic (including storage and signing for keys; digi-pad codes; opening/locking up arrangements by external companies). • Local security arrangements for assets and equipment – both NHS and personal. • Arrival/departure from offices/clinic/department at night or early morning – consider arriving/leaving in pairs. • Awareness of local issues. • Escalation of concerns either pro-actively or reactively including details of On Call arrangements. • Directed to Security and Management of Violence and Aggression Policy for further details. • Escalation process for Estates and Facilities Management Issues. • Signed for any keys or code issued.	
2	**Lone Working** (keep in mind staff working early or late) • Buddying arrangements/Role Risk Assessment • Diary sharing • **"Code words"** used to alert a team member that a colleague is under duress and in need of assistance. Protocols for escalation of concerns. • Record of staff member's car, make, model and registration (community staff). • NOK for contact (in case of need).	

	• Directed to Lone Worker Procedure for further details.	
3	**Reporting of incidents** • How incidents are reported • Types of incidents and near misses that need to be reported. • Escalation of concerns. • Where to go for help?	
4	**Risk assessing** • Types of risk assessment (H&S; lone working; risk of violence and aggression, etc) • Where information may be found (intranet; policies) • Contacts – LSMS; H&S Adviser; Fire Adviser • Directed to Management of Violence and Aggression Procedures	
5	**Local Issues (Specify issue and how managed)** Patient's property procedures (KIV patient's homes and their property) Handling/storage of cash and/or valuables. Delivery/Handling of packages (including handling of suspect packages/bomb threat) & Lockdown procedures and processes [where appropriate] Medical gasses – storage/handling CCTV – awareness of any system and who it is managed by.	
Comments…		

Manager's details	**Staff member's details**

Date completed:

Appendix 2

INCIDENT INFORMATION SHEET FOR POLICE

Please provide as much information as possible as this will help the Police to determine the most appropriate course of action and be aware who they may contact to gather further information.

PART 1: TO BE COMPLETED BY / ON BEHALF OF VICTIM			
Victim preference for the incident to be recorded? ***If yes - FEC for filing**	**Yes*/No**	**Victim preference for formal police action / prosecution** **(Incident will be investigated to establish what lines of enquiry there are)**	**Yes*/No**
Name and contact details of Single Point of Contact for Police in respect of this incident **Name** **Telephone number and extension** **SECURE email**			

DATE &TIME OF INCIDENT:	LOCATION OF INCIDENT:	RIO PROGRESS NOTE DATE & TIME:	NHS INCIDENT REPORT NO.

What is Alleged? e.g assault, property damage, threat of harm

VICTIM/AGGRIEVED: Name: D.O.B (Mandatory requirement): *Home address:*	Ethnicity(See chart below):	
e-mail address: *Telephone number:*		
Is the victim a patient*, visitor, member of staff?	Y	N
Is the victim willing to support police action / prosecution in this case?	Y	N
*If the victim is also a patient, then provide details of their Consultant/RC and MHA status		

SUSPECT: Name: D.O.B: Address [if known] If patient; Mental Health Act Status: Name of the Consultant/ RC:	Ethnicity (See chart last page of form):

WITNESSES:*(please include additional information if more than two witnesses]*	
SHFT Staff Yes/No Name: *Home address:*	SHFT Staff Yes/No Name: *Home address:*
e-mail address:	*e-mail address:*
Telephone number:	*Telephone number:*

VICTIM / AGGRIEVED STATEMENT: If more than one victim, each victim should complete a separate report. This can be used as a guide
I am employed by the NHS in the role of: Where did the incident occur? Who was present? Was there any build up to the assault? Have there been previous incidents with this patient assaulting or being aggressive toward you? What happened? If in restraint why do you believe the action was deliberate.

Where did the blows land?

What injuries were caused and how? (fist, kick etc). Include any other details e.g. black eye, cuts, headache, sickness?

What treatment was sought? Please detail any medical treatment required.

How did the incident make you feel?

Did the incident make you fear for your safety?

Has the patient apologised?

How do you feel about working with the patient now? Has the incident changed your working practices?

How long you have known the patient?

How often you work with them?

Are you sure it was them who assaulted you?

Was the lighting good? Could you clearly see them?

How close were you to them [use a measurement you understand eg metres, bus/car lengths etc.]

If damage confirm you/ the trust did not give them permission for the damage to be done

Racially or Religiously motivated? Offender Demonstrates hostility based on victims membership (or

presumed membership) of a racial or religious group or offence motivated by hostility towards members of a racial or religious group based on their membership of that group. Actual words used if possible

DETAILS OF ANY EXHIBITS e.g. photographs taken of damage or injuries, CCTV images*, preserved weapons.

- Please ensure the CCTV clearly shows the offender and the commission of the offence

1.	4.
2.	5.
3.	6.

AGGRIEVED/VICTIM DECLARATIONS:

Would you be willing to attend court if necessary? **YES / NO**

Do you give consent to police accessing you medical records relating to the incident? (if serious incident that required prolonged medical attention)**YES / NO**

Do you consent to having your medical records relating to the incident disclosed to the defence? **YES / NO**

I believe that at the time of the incident, the person knew what they were doing was wrong and that they intended to cause harm / damage to property.

Signature……**Print** ……**Date**…….

DETAILS OF PERSON COMPLETING FORM (if different from victim / aggrieved)

Name:

Band

Signature: **Date:**

PART 2: TO BE COMPLETED BY CONSULTANT / RESPONSIBLE CLINICIAN	
Why is this incident being referred to the police? (tick all that apply)	
The behaviour is persistent.	
The behaviour has a negative impact on other patients and ward routines.	
Internal measures / sanctions have been exhausted	
In order to provide a consequence for the suspect's actions	
The suspect has a recent history of offending within the unit / team	
Criminal justice intervention is needed to safeguard the public or those providing care or services to the person	

At the time of the incident, in my clinical opinion, I consider that the person had **capacity** to understand their actions.

Signed: _____ Print Name_____Date: _____

The above named suspect **is/is not** fit to be interviewed by the police.

Signed: _____ Print Name_____Date: _____

Police intervention would not be detrimental to the care / treatment of the named suspect in this incident.

Signed: _____ Print Name_____Date:

Contact Details

Once completed, this form can be emailed* to postmaster@hampshire.pnn.police.uk or the incident can be reported by telephoning 101 [Police non-emergency number].

***If emailing - in the body of the email;**

-ask for a crime reference number
-reinforce if it is for recording only or for further action.
-where there are multiple incidents involving the same suspect please request that the incident is considered as a related occurrence and provide earlier police reference numbers.

Because of the nature of the incident – safeguarding procedures have been initiated	**Yes/No**
if No - Police will complete CYP/CA12	

Part 3: to be completed by security staff / ward manager / team leader	
REPORTED TO POLICE BY:	
Date reported:	**TEL CONTACT:**
POLICE REFERENCE NUMBER:	

Ethnicity Codes

Code	Ethnicity
IC1	White - North European
IC2	White - South European
IC3	Black
IC4	Asian (in the UK Asian refers to people from the Indian subcontinent like India, Pakistan, Bangladesh, Nepal)
IC5	Chinese, Japanese, or other South East Asian
IC6	Arabic or North African
IC9	Unknown
IC2	White - South European
IC3	Black

Appendix 3

Training Needs Analysis

If there are any training implications in your policy, please complete the form below and make an appointment with the LEaD department (Louise Hartland, Quality, Governance and Compliance on 02380 874091) before the policy goes through the Trust policy approval process.

Topic/Subject		Frequency	Course Length	Delivery Method	Facilitators	Recording Attendance	Strategic & Operational Responsibility
Conflict Resolution Training		**Once followed by refresher every 3 years**	**Initial and Refresher – 3.5 hours**	**Face to face**	**LEaD**	**LEaD**	**Strategic - Medical Director Operational - Head of Nursing, AHP and Quality for MH.**
Service		**Target Audience**					
MH/LD	**Adult Mental Health**	All staff who are not required to complete Supporting Safer Services (sSs) training					
	Specialised Services						
	Learning Disability Services						
	Older Persons Mental Health						
ISD	**Adults**	All Staff					
	Childrens Services & Quit for Life						
Corporate	**Director of Nursing**						
	Medical Director						
	Chief Executive						
	Chief Financial Officer						
	Development Director						
	People of Communications						
	Property and Estates						

Topic/Subject		Frequency	Course Length	Delivery Method	Facilitators	Recording Attendance	Strategic & Operational Responsibility
Supporting Safer Services (sSs)		**Full programme once only followed by annual Refresher**	**Full programme – 30 hours Refresher – 15 hours**	**Face to face**	**LEaD**	**LEaD**	**Strategic - Medical Director Operational - Head of Nursing, AHP and Quality for MH.**
Service		**Target Audience**					
MH/LD	**Adult Mental Health**	All registered nurses, mental health practitioners, trainee practitioners and health care support workers who work in the following services; Elmleigh (Elmleigh Inpatients, Elmleigh FM); Antelope House (Hamtun, Trinity & Saxon wards); Parklands Hospital (Hawthorns Inpatients, Hawthorns MOD & Hawthorns PICU); Melbury Lodge (Kingsley Ward & Mother & Baby Unit).					
	Specialised Services	All registered nurses, mental health practitioners, trainee practitioners and health care support workers who work in the following services; Leigh House All registered nurses, mental health practitioners, occupational therapists, OT technicians, trainee practitioners and health care support workers who work in the following services; Ashford Unit, Ravenswood House (RSU Clinical Management, RSU Ashurst, RSU Lyndhurst, RSU Malcolm Faulk Ward, RSU Mary Graham Ward, Meon Valley Ward, RSU Therapies, RSU Clinical Risk & Security Liaison, RSU Support Services); Southfield (Cedar, Oak and Beech wards, Southfield OT & Southfield Reception and Security); Bluebird House (Bluebird Nursing & Security, Hill Ward, Moss Ward & Stewart wards, Bluebird House Site Services, Bluebird House OT, Bluebird Staff Dummy) and Specialised Services Management.					
	Learning Disability Services	All registered nurses, assistant/associate practitioners, and health care support workers who work in the following services; Willow Assessment & Treatment Unit;					
	Older Persons Mental Health	All registered nurses, mental health practitioners, trainee practitioners and health care support workers who work in the following services; Gosport War Memorial Hospital (Dryad & Daedalus wards); Melbury Lodge (Stefano Oliveri ward); Parklands Hospital (Beechwood & Elmwood wards) and Western Community Hospital (Beaulieu & Berrywood). All inpatient modern matrons (OPMH Western Management).					
ISD	**Adults**	Not Applicable					
	Childrens Services & Quit for Life						
Corporate	**Director of Nursing**						
	Medical Director						
	Chief Executive						
	Chief Financial Officer						
	Development Director						
	People and Communications						
	Property and Estates						
	Strategy Director						

APPENDIX 4 - Southern Health NHS Foundation Trust:
Equality Impact Analysis Screening Tool

Equality Impact Assessment (or 'Equality Analysis') is a process of systematically analysing a new or existing policy/practice or service to identify what impact or likely impact it will have on protected groups.

It involves using equality information, and the results of engagement with protected groups and others, to understand the actual effect or the potential effect of your functions, policies or decisions. The form is a written record that demonstrates that you have shown *due regard* to the need to **eliminate unlawful discrimination**, **advance equality of opportunity** and **foster good relations** with respect to the characteristics protected by equality law.

For guidance and support in completing this form please contact a member of the Equality and Diversity team.

Name of policy:	Security and Management of Violence and Aggression Policy
Policy Number:	SH NCP 21
Department:	Health and Safety Forum
Lead officer for assessment:	Jan Macavoy - Local Security Management Specialist
Date Assessment Carried Out:	February 2017

1. Identify the aims of the policy and how it is implemented.	
Key questions	**Answers / Notes**
Briefly describe purpose of the policy including • How the policy is delivered and by whom • Intended outcomes	Creating and maintaining a safe and secure environment for the staff it employs, the health and safety of the service users, that is patients, visitors, contractors and all persons who visit Trust premises or premises on which the Trust operates. Tackling violence and aggression and protecting lone workers. This policy has been written to ensure to support the organisational framework for promoting equality and eliminating discrimination (Equality Delivery System): ✓ Service users and their carers should be made aware of the policy and its procedures ✓ Service users and their carers should be involved in shared decision-making about the management of violent/aggressive behaviour through the use of their care plans **Person-centred care** In order to create a genuinely patient-centred service several processes should be created to enable users to contribute to the design and delivery of care. The aim is to promote a non-

	judgemental, non-patronising, collaborative approach to care (Department of Health, Mental health policy implementation guide 2002, p14). **United Kingdom Central Council for Nursing, Midwifery and Health Visiting** Violence directed to staff, patients or visitors is completely unacceptable. We should start from a position of Zero Tolerance, but then recognise that some patients, because of their illness, may behave in a violent (physical and non-physical manner) and that this condition may need special consideration. Organisations must support their staff fully when it comes to prosecution of perpetrators and develop and use strong links with the police and criminal justice system to ensure that mental illness or personality disorder per se or simply being a "patient in care", does not absolve perpetrators from the legal consequences of their actions.

2. Consideration of available data, research and information

Monitoring data and other information involves using equality information, and the results of engagement with protected groups and others, to understand the actual effect or the potential effect of your functions, policies or decisions. It can help you to identify practical steps to tackle any negative effects or discrimination, to advance equality and to foster good relations.

Please consider the availability of the following as potential sources:

- **Demographic** data and other statistics, including census findings
- Recent **research** findings (local and national)
- Results from **consultation or engagement** you have undertaken
- Service user **monitoring data**
- Information from **relevant groups** or agencies, for example trade unions and voluntary/community organisations
- Analysis of records of enquiries about your service, or **complaints** or **compliments** about them
- Recommendations of **external inspections** or audit reports

	Key questions	**Data, research and information that you can refer to**
2.1	What is the equalities profile of the team delivering the service/policy?	The policy is relevant to all Trust staff. The Equality and Diversity team will report on Workforce data on an annual basis.
2.2	What equalities training have staff received?	All Trust staff undertake Equality and Diversity training as part of Corporate Induction

		(Respect and Values) and E-Learning LEaD Training programmes in the management of violence
2.3	What is the equalities profile of service users?	The Equality and Diversity team will report on patient data on an annual basis.
2.4	What other data do you have in terms of service users or staff? (e.g results of customer satisfaction surveys, consultation findings). Are there any gaps? The effectiveness of this policy will be reviewed on an annual basis and assessed by reviewing its implementation and application across the organisation in line with the requirements of the NHSLA minimum data set for Standard 4 – Safe Environment review will be led by the LSMS and approved by the MOVA and Health & Safety Committee. The Trust is aware and acknowledges the following resources: ✓ Department of Health (1999) Homicides and Suicides Inquiry ✓ Department of Health (1999) Zero Tolerance ✓ Mental Health Act (1983) Code of Practice ✓ Royal college of Psychiatrists (1997) Guidelines on the Management of Imminent violence ✓ United Kingdom Central Council (2002) The recognition, prevention and therapeutic management of violence and aggression ✓ NICE (2005) Short term management of violent behaviour	The Trust is preparing to implement the Equality Delivery System which will allow a robust examination of Trust performance on Equality, Diversity and Human Rights. This will be based on 4 key objectives that include: 1. Better health outcomes for all 2. Improved patient access and experience 3. Empowered, engaged and included staff 4. Inclusive leadership
2.5	What internal engagement or consultation has been undertaken as part of this EIA and with whom? What were the results? Service users/carers/Staff	✓ Management of Violence and aggression Committee (MOVA) ✓ Health & Safety Committee ✓ Quality &Safety Committee ✓ Trust Equality and Diversity Lead
2.6	What external engagement or consultation has been undertaken as part of this EIA and with whom? What were the results? General Public/Commissioners/Local Authority/Voluntary Organisations	

Equality Impact Assessment – Screening Tool

	Positive impact (including examples of what the policy/service has done to promote equality)	**Negative Impact**	**Action Plan to address negative impact**			
			Actions to overcome problem/barrier	**Resources required**	**Responsibility**	**Target date**
Age	**Applied to all Protected Characteristics:** Everyone has a duty to behave in an acceptable and appropriate manner. Staff have a right to work, as patients have a right to be treated, free from fear of assault and abuse in an environment that is safe and secure.	Unqualified and junior staff are at greater risk than more senior, experienced staff (United Kingdom Central Council (2002) (Gournay et al, 2000) shows that the most vulnerable members of nursing staff are those in the lower grades and that staff aged between 21 and 32 are almost twice as likely to be assaulted than staff over the age of 46. Incidents not considered serious enough (Beale et al 1999) - although serious incidents are not always	**Applied to all Protected Characteristics:** Monitoring ✓ Number of incidents being reported; ✓ Number of incidents passed onward to the Security Management team; ✓ The uptake of training programmes; ✓ Information staff exit interviews; **Employees** can expect that the Trust will: Uphold the principles of the Human Rights Act that all individuals should be treated with		Local Security Management Specialist	On-going: EqIA will be reviewed at Policy Review stage and monitoring data will be used to inform any changes

		reported (Owen et al 1998) Some community staff workplace may be patient's home: This Policy should be read in conjunction with the Trust Lone Working Policy	fairness, respect, equality, dignity and autonomy Investigate all reported incidents of violence and aggression Undertake continual monitoring and evaluation of such incidents Provide advice, support and counselling to any employee involved in a violent or aggressive incident Provide appropriate training to employees in dealing with potentially violent or aggressive situations			
Disability	The Trust will ensure that all its facilities and estates are accessible and safe through: Disability Access Audits and the design of service areas and personal alarms	Patients with a dual diagnosis (co-existing mental illness and substance misuse) are much more likely to perpetrate a violent act than people with mental			Estates and Facilities Management Local Security Management Specialist	On-going: EqIA will be reviewed at Policy Review stage and monitoring data will be used to

		illness alone (United Kingdom Central Council (2002) Effects of sensory Impairment: It has been noted that service users with sensory impairments are particularly vulnerable when managing violence and aggression. One such example is the restraining of a deaf service user's hands, thereby preventing them from communicating.				inform any changes
Gender Reassignment		Transgender people may experience violence and aggression	Appropriate management of single sex accommodation		Local Security Management Specialist	On-going: EqIA will be reviewed at Policy Review stage and monitoring data will be used to inform any changes
Marriage and Civil						On-going: EqIA

Partnership						will be reviewed at Policy Review stage and monitoring data will be used to inform any changes
Pregnancy and Maternity		Some community staff workplace may be patient's home	Trust Lone Worker and individual staff risk assessments	Conflict Resolution Training	Local Security Management Specialist	On-going: EqIA will be reviewed at Policy Review stage and monitoring data will be used to inform any changes
Race	The David Bennett Inquiry (2004) highlighted the importance of considering the needs of black and minority ethnic groups when managing disturbed/violent behaviour in the short-term.	Discrimination based upon race affecting staff and service users The effects of violence and aggression are wide-ranging and include not only physical injury, sometimes necessitating medical treatment, but also the emotional consequences which	Policy and procedure will support staff in dealing with racist incidents		Local Security Management Specialist	On-going: EqIA will be reviewed at Policy Review stage and monitoring data will be used to inform any changes

		sometimes amount to post traumatic stress disorder				
Religion or Belief		The Trust needs to be aware that abusers often target people because they are different and sometimes an individual's religion, belief or non-belief may be a trigger. Multi-faith concerns: ✓ Possession of Kirpan.			Local Security Management Specialist	On-going: EqIA will be reviewed at Policy Review stage and monitoring data will be used to inform any changes
Sex	In terms of managing violent/aggressive behaviour in psychiatric in-patient settings, the main concern raised in *The women and mental health strategy* has been to identify gender specific needs, such as single-sex facilities, and to ensure that both male and female service users feel safe, listened to and	Although no direct adverse impact has been found directly relating to this policy, the organisation needs to be aware that women are disproportionately aggrieveds of abuse. Research by Women's Aid in October 2007: While 1 in 4 adult women and 1 in 13 adult men will experience				On-going: EqIA will be reviewed at Policy Review stage and monitoring data will be used to inform any changes

	involved in identifying and meeting gender related needs (*Mainstreaming gender and women's mental health implementation guide* 2003).	domestic violence during their lifetimes findings from the research found that vulnerable women and men are at increased risk of abuse; 1 in 2 disabled women have experienced domestic abuse compared with 1 in 4 of non-disabled women. A potentially serious degree of harm can be inflicted without physical contact being made has now been recognised in law. For example, there have now been a number of successful prosecutions for grievous bodily harm brought against stalkers. In-Patient settings: Service Users Body Building through weight				

		training and/or consumption of supplements to increase strength and body weight				
Sexual Orientation		Gay, lesbian and bisexual individuals are likely to face additional concerns around homophobia and gender discrimination.	It is important that staff are trained to be aware of the specific requirements of the Equality Act 2010 and Human Rights Act. Human rights will therefore be reflected where it is appropriate to do so in general training within SHFT. This includes Corporate Induction Training, Respect and Values and E-Learning.		Equality and Diversity Lead	On-going: EqIA will be reviewed at Policy Review stage and monitoring data will be used to inform any changes