DH Department of Health

A Department of Health Consultation Paper

Tackling nuisance or disturbance behaviour on NHS healthcare premises: a paper for consultation

Foreword

All NHS staff and patients should expect to work and be treated in an environment that is properly secure so that the highest possible standards of clinical care can be made available. Behaviour that causes a nuisance or disturbance within the NHS has a serious impact on those who are there to provide high-quality treatment for the most vulnerable in our society. Dealing with this behaviour takes resources away from where they are needed – patient care. It may also give the misleading impression that the NHS tolerates poor behaviour committed by a minority of anti-social individuals.

In November 2003, the Government introduced a comprehensive framework to tackle issues such as violence against NHS staff, sending a strong message that violent or abusive behaviour is not acceptable and will not be tolerated. Progress in tackling this problem has already been made; since 2002–03, we have already seen a fifteen-fold increase in the number of prosecutions identified involving those who have physically assaulted staff, and Healthcare Commission staff surveys have demonstrated year-on-year reductions in the number of staff who say that they have been assaulted.

However, we do not simply want to react when something has happened, where a member of staff has already been assaulted and possibly injured. That is why we have introduced the largest-ever training programme in the NHS, and it is estimated that, by the end of March 2006, over a quarter of a million NHS frontline staff had been trained in how to prevent and manage violence.

We recognise that more needs to be done to help prevent such incidents from occurring in the first place, ensuring that there is a strong deterrent in place for those who may be minded to act in this way. Within the context of the Government's Respect Action Plan, we want to ensure that NHS staff are given the respect they deserve and, where there is an identifiable problem with nuisance or disturbance behaviour, to consider whether NHS health bodies have the necessary legal powers to deal with such behaviour, particularly where it has the potential to escalate into more serious incidents.

With this in mind, I would invite your views on the proposals contained in this consultation paper, which are designed to help us consider legislation to enable NHS health bodies to deal effectively with individuals who create a nuisance or disturbance on NHS premises, as well as the safeguards that need to be in place to ensure the vulnerable are properly protected.

Caroline Flint
Minister of State for Public Health

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1. Executive summary

1.1. In some areas of the NHS, incidents of low-level nuisance or disturbance behaviour can cause particular problems. Dealing with such incidents diverts staff from their job of delivering healthcare, which means that less time and fewer resources are available for patient care. For both staff and patients, it may contribute to an environment in which they feel less safe and secure. Although these types of incidents may not be as immediately damaging as other more serious incidents, such as those involving violence, they can lead to low staff morale, absenteeism and, potentially, staff leaving the NHS altogether. Furthermore, this type of behaviour can escalate into more serious situations, such as physical assaults on staff, theft of NHS assets and damage to NHS property.

1.2. The Government's Respect Programme focuses on the need for two-way respect, between workers serving the public and the individuals and communities to whom they provide a service. All members of the public have a right to enter NHS healthcare premises to receive the treatment that they need and are entitled to. However, with that right comes a responsibility to behave and act in an appropriate manner. In certain circumstances, when a person behaves in a way that causes a nuisance or disturbance to staff or other patients without a reasonable excuse or a medical justification, they may be asked to leave the premises. If a person fails to leave NHS premises when asked to do so, they will no longer have the right to be on those premises. This will be backed by a Code of Conduct and tailored staff training which will clearly set out the process before invoking the power of removal and the need to resolve any problems politely and through respectful discussion with the individual.

1.3. This behaviour may not be covered by existing law – for example, under Public Order or Anti-Social Behaviour legislation. This means that it is not always appropriate for the police to respond to incidents involving nuisance or disturbance behaviour. If an offender persistently causes a problem, an injunction may be sought through the civil courts, but additional tools may be required. Increasing the number of security staff within NHS health bodies would be a welcomed step, helping to increase the level of visible deterrence against all forms of crime. However, these staff would still be powerless to remove people from the NHS premises where they were being a nuisance or creating a disturbance. None of these options presents NHS health bodies with an immediate solution to dealing with this behaviour as it occurs.

1.4. This consultation paper proposes that consideration be given to new legislation to help combat such behaviour where it is impacting on the delivery of healthcare to NHS patients, and to address the gap in current arrangements that has been identified. It is believed that this, alongside other measures that have been introduced, will help tackle

such behaviour on NHS healthcare premises, and help to create a safer and more secure environment for all those who work in or use the NHS. This paper seeks comments on the need for such legislation and all aspects of its formulation and use. It should be read in conjunction with the partial Regulatory Impact Assessment published alongside this document, which contains an analysis of the potential benefits and impacts of these proposals.

2. Background

2.1. The Security Management Service (SMS) is part of the Counter Fraud and Security Management Service (CFSMS), a division of the NHS Business Services Authority (a Special Health Authority), and has overall responsibility for all policy and operational matters related to the management of security in the NHS. On behalf of the Secretary of State for Health, the NHS SMS determines the policies, legal framework, operational guidance and minimum standards necessary to ensure that the objective of providing a secure environment for the NHS can be achieved. It also provides central and regional support to those charged with undertaking security management work in health bodies, so that the required standards can be met. Specific areas of priority action include tackling violence against NHS staff, ensuring the security of NHS property and assets and ensuring the security of maternity and paediatric units. Further information on the work of the NHS SMS can be found on the NHS CFSMS website – www.cfsms.nhs.uk.

2.2. As stated, a key responsibility of the NHS SMS is tackling violence against NHS staff. Accurate figures recently produced by the NHS SMS show that in 2004–05 there were 43,097 physical assaults against NHS staff working in mental health and learning disability settings, 10,755 in the acute sector, 5,192 in Primary Care Trusts and 1,333 in Ambulance Trusts.

2.3. The NHS SMS has commenced a programme of work to obtain accurate information on the nature, scale and extent of all security-related problems in the NHS. Although overall data from this will not be available until the end of 2006–07, the information already available about physical assaults indicates a need to consider measures that may help to prevent assaults on NHS staff.

3. NHS security management work

3.1. In November 2003, as part of the comprehensive strategy to make the NHS a safer and more secure place to work, a new national framework was introduced to tackle the problem of violence against NHS staff. Within this framework, a number of measures have been introduced, including:

- a national reporting system for physical assaults and consistent reporting procedures for non-physical assaults on NHS staff
- a Legal Protection Unit (LPU) to work with the police and Crown Prosecution Service (CPS) to increase the number of sanctions taken against those who assault or abuse NHS staff
- training of Local Security Management Specialists (LSMSs) in each NHS health body.

3.2. The NHS SMS has worked hard to ensure that all NHS health bodies adopt these measures, including encouraging Foundation Trusts to fully participate within this new national framework.

3.3. To address issues of cooperation and build a better understanding between NHS health bodies and their local police forces, a Memorandum of Understanding (MoU) with the Association of Chief Police Officers (ACPO) has been agreed and will be published in the near future. A key objective of the MoU will be to ensure that the NHS and the police work together to make more effective use of the existing criminal law to deal with crime; for example, where a physical assault has occurred, to ensure the perpetrators are held to account.

3.4. The NHS SMS has also worked successfully with the police and the CPS to increase the number of successful prosecutions taken against offenders, as well as supporting the NHS in pursuing private prosecutions, particularly against those who commit serious offences of physical assault against NHS staff. Figures released in August 2005 show a fifteen-fold increase in the number of identified prosecutions, from 51 in 2002–03 to 759 in 2004–05.

Examples of prosecutions:

- *The first private prosecution brought by the NHS SMS's Legal Protection Unit resulted in a successful prosecution on 9 November 2005. The assailant assaulted a community nurse from Burnley and was sentenced to a two-year conditional discharge and ordered to pay compensation and costs.*
- *In May 2004, a nurse was assaulted by a patient, resulting in severe injuries. A private prosecution was commenced, leading to the defendant pleading guilty to unlawful and malicious*

wounding. In January 2006, the defendant was sentenced to two years' probation with a condition of psychiatric treatment and 80 hours' community punishment. He was ordered to pay £2,500 in compensation to the victim.

4. The current position

4.1. An analysis of the impact of crime within the NHS and the potential benefits of these proposals (based on information currently available) is contained within the partial Regulatory Impact Assessment that has been published alongside this document.

4.2. Based on the number of physical assaults on NHS staff reported in 2004–05, it is estimated that violence against staff could cost the NHS between £10m and £270m per annum, depending on the degree of absenteeism due to sickness that can be attributed to an assault. Staff surveys carried out by the NHS SMS demonstrated that around 20% of staff did not feel that the NHS provided them with a safe and secure environment to work in and, from a public opinion poll, 76% of the public felt very concerned about violence against NHS staff.

4.3. It is clear that the emphasis needs to be on the prevention of crime, including assaults on staff, if the NHS is to deliver a truly safe and secure environment for both staff and patients, and if it is to reduce both the human and financial impact of crime on the service. It is recognised that simply prosecuting individuals when an assault has occurred, though important in itself, is a reactive measure and that much more needs to be done to help prevent incidents such as physical assaults from occurring in the first place.

4.4. Nuisance or disturbance behaviour causes a particular problem for the NHS and needs to be tackled, due to its impact on staff and patients. In addition, if not dealt with, it has the potential to escalate into more serious incidents, such as physical assaults on staff, theft of NHS assets or damage to NHS property.

4.5. This type of incident may not be as immediately damaging as other more serious incidents of actual violence or abuse, but it is thought that the impact on the NHS in the long term – in terms of low staff morale, absenteeism and staff leaving the NHS – may nevertheless be significant.

Examples of incidents:

- *A mental health trust in the north of England has encountered problems with an ex-service user who, after discharge, consistently returns to the premises, without good reason and not requiring medical treatment, causing a disturbance and nuisance to staff and other service users.*

- *A large acute trust recently had problems in dealing with a large group of individuals attending a hospital with a family member. The group persistently ignored no smoking signs, created mess in the toilets and caused a nuisance to other visitors and patients.*

- *A Local Security Management Specialist within a health body told how he and his security staff often felt like 'toothless tigers' when waiting for the police to attend and remove nuisance individuals: "The police are under constant pressure to deal with serious incidents. When we request assistance in the removal of individuals, more often than not this is a low-profile police response and we can end up babysitting these individuals for hours before we are able to remove them with police assistance".*

4.6. There is existing criminal legislation that deals with incidents of more serious anti-social behaviour. For example, it is an offence under section 5 of the Public Order Act 1986 to use threatening, abusive or insulting words or behaviour, or disorderly behaviour, within the hearing or sight of a person likely to be caused harassment, alarm or distress thereby. In addition, the police may apply for an Anti-Social Behaviour Order (Asbo) under section 1 of the Crime and Disorder Act 1998 (c.37) in circumstances 'where a person has acted in a manner that caused or was likely to cause harassment, alarm or distress to one or more persons not in the same household as himself'.

4.7. These existing powers do not always provide NHS bodies with sufficient protection from those who behave in a disruptive manner on NHS premises. Certain behaviour may not satisfy the threshold for the public order offences but nevertheless have the potential to adversely affect the ability of NHS staff to deliver healthcare. Further, while disruptive behaviour may in some cases form a sufficient basis for the issuing of an Asbo, a person who is behaving in such a manner on NHS premises will not have committed an offence unless there is a relevant Asbo in place at the time.

4.8. Currently, NHS health bodies have two options open to them to deal with nuisance or disturbance behaviour. The first is to seek the assistance of the police to remove offenders. However, if the behaviour in question falls short of the existing public order and anti-social behaviour offences, it may not be appropriate for the police to respond. Where this is the case, NHS security personnel will have no power to remove the person from NHS premises. This creates an atmosphere which makes the occurrence of a more serious incident more likely and gives both staff and patients the misleading impression that the NHS tolerates such bad behaviour.

4.9. Alternatively, NHS health bodies can resort to the use of the civil law to obtain injunctions against individuals who cause a nuisance or disturbance, to prevent them from entering NHS premises, but this can often be time-consuming, slow and costly. Legislation is currently being introduced to improve this situation; however, the use of injunctions

remains more appropriate for persistent offenders.

4.10. As can be seen, these options do not present health bodies with an effective solution to nuisance or disturbance behaviour, nor do they adequately address the issue of tackling this behaviour before it escalates into more serious incidents, which impact on the delivery of healthcare.

5. What measures can be introduced to deal with the problem of behaviour that causes a nuisance or disturbance on NHS healthcare premises?

5.1. There appear to be two main options for dealing with the problem of behaviour that causes a nuisance or disturbance on NHS premises.

5.2. The first option is to increase the provision of security staff within the NHS. While such investment would be welcomed, employing extra security staff would, at best, act as a visible deterrent and reduce the potential for crime to occur. However, the problem would still remain that security officers have no effective powers to remove a person from NHS premises, where that person is acting in a manner that causes a nuisance or disturbance to others.

5.3. The second option is to consider introducing new legislation to create an offence of causing a nuisance or disturbance on NHS premises, together with a power for certain NHS employees to remove the person creating the nuisance or disturbance. Similar legislation already exists for the education sector. Section 547 of the Education Act 1996 (c.56) created an offence of nuisance or disturbance on school premises with a related power, exercisable by a person authorised by a local education authority, to remove a person committing the offence. Although there are no national statistics on the use and impact of this legislation within schools, it is understood to have helped create a deterrent effect in some areas against such behaviour.

5.4. Similar legislation in relation to NHS premises would give NHS health bodies an additional tool to deal with individuals creating a nuisance or disturbance on NHS premises. It is strongly believed that – with the right legal structure, training and guidance – this measure can be made to work within an NHS healthcare setting, without impacting on those who have a genuine right and need to be there.

6. New legislation and what it might cover: offence of nuisance or disturbance behaviour on NHS healthcare premises and a power to remove such individuals from NHS healthcare premises

6.1. The new legislation would create an offence of creating nuisance or disturbance on NHS premises, together with a power for certain NHS employees to remove the person creating the nuisance or disturbance.

The offence

6.2. The proposed offence would consist of three elements. The offender would need to:

- be present on NHS premises
- be creating a nuisance or disturbance to the annoyance of persons employed by or contracted to the health body
- refuse to leave the premises when asked to do so.

NHS premises

6.3. It is envisaged that the legislation would cover NHS trusts, Primary Care Trusts (PCTs) and NHS foundation trusts and would be restricted to the buildings, premises or lands owned, leased or managed by such NHS health bodies. Examples could include an NHS hospital, clinic or walk-in centre. The legislation would cover all internal areas of buildings, as well as external areas such as car parks, paths and parkland.

6.4. It is not proposed that premises owned, leased or managed by those who provide services to the NHS under a contract, such as a General Practitioner (GP)'s surgery, would be covered, unless they operated from premises owned, managed or leased by a PCT, for example. There is already a scheme in place to treat violent or abusive individuals within the community, known as the Violent Patient Scheme (VPS). In addition, as these proposals envisage having a structure (which already exists in many NHS health bodies through the work of the NHS SMS) in place to operate powers under legislation, such as a 'responsible' person and trained security personnel, it is recognised that they would be disproportionate or too costly for such practitioners to operate.

6.5. It is not proposed that 'NHS premises' would include ambulance vehicles, as the necessary structures are not likely to be available in these situations. In addition, there is legislation currently before Parliament – the Emergency Workers (Obstruction) Bill, to create an

offence of obstructing or hindering an ambulance worker in the course of responding to an emergency.

Creating a nuisance or disturbance

6.6. These proposals are not designed to replace ways of dealing with more serious types of anti-social or criminal behaviour, which will continue to be reported to the police and dealt with under existing legislation. However, the new legislation would give NHS health bodies, where they wish to use these additional powers, the tools to deal with lower-level problem behaviour, which is not adequately dealt with at this time.

6.7. It is proposed that this legislation would cover situations where a person who is causing a nuisance or a disturbance that is impacting on the delivery of healthcare for others – diverting resources from the treatment of patients – has been asked to leave and refused to do so. It is suggested that examples might include:

- Members of the public who, through their behaviour, are causing a nuisance or disturbance, generally disturbing other patients and staff – for example, the second example given at paragraph 4.5.

- A member of the public who does not require medical treatment, but who is persistently complaining or requesting the attention of staff, without any legitimate basis for that complaint or genuine medical need.

- A member of the public who does not require medical treatment, but who is making a great deal of noise – for instance, in the immediate vicinity of a treatment area, which prevents a medical practitioner from treating a patient.

Refusal to leave the premises

6.8. It is proposed that behaviour causing a nuisance or disturbance, where a person refuses to moderate their behaviour or leave when politely requested to do so, would constitute an offence and could lead to the offender being removed from those NHS healthcare premises.

The sanction

6.9. The matter would also be reported to the police to allow them to investigate and consider whether it needs to be referred to the CPS for prosecution. It is intended that it would be a summary only offence, triable in the magistrates' courts and punishable by a fine not exceeding level 3 on the standard scale (currently £1000).

The power of removal

6.10. It is proposed that where there are reasonable grounds for suspecting a person has committed an offence, and they have refused to leave the premises when asked to do so, a person authorised by the relevant NHS body may remove them from the premises.

Questions

1. Do you agree that a new offence and power of removal is needed to deal with the problem of nuisance or disturbance behaviour on NHS healthcare premises?
2. Do you agree that section 547 of the Education Act 1996 (c.56) offence is a suitable model for use within the NHS?
3. Which types of behaviour should be covered?
4. Which types of NHS bodies and NHS premises should be covered by these proposals?
5. Is the proposed sanction appropriate and proportionate?

7. Authorising and exercising the power of removal

Authorising the use of the power of removal – the 'responsible person'

7.1. It is proposed that the exercise of the power of removal by NHS health bodies under such legislation be voluntary, where they have identified problems with this type of behaviour. It may not be appropriate for some NHS health bodies to use this power; as they may not have a problem with this nuisance or disturbance behaviour, as in the case of some Primary Care Trusts (PCTs), which may only commission – not deliver – NHS services. It would be disproportionate and illogical for them to implement a regime that they will never use. Making the exercise of this power voluntary also ensures that no unnecessary burdens are placed on frontline staff and should be seen in the context of providing an additional tool to deal with an existing problem.

7.2. It is suggested under these proposals that the decision as to whether there is sufficient reason to believe that a person may have committed such an offence and should be removed would be taken by a 'responsible person', as authorised by the Chief Executive of the appropriate NHS health body. Under the structure envisaged for the operation of this power, it is further suggested that this should normally be the Local Security Management Specialist (LSMS) or nominated deputy. The LSMS will already have been trained and accredited by the NHS SMS to manage security in a professional and expert manner, as well as to act in a fair and objective fashion. Specific training on the use of this legislation will be provided to the 'responsible person' who, where appropriate, will make the decision to remove in full consultation with a medical practitioner. Guidance, training and a code of practice will also outline the steps that the 'responsible person' would need to take before a person is removed. In every instance, they would be required to demonstrate that all efforts were made to resolve the situation – through reasonable requests for the individual to moderate their behaviour or leave the premises – before the power afforded by the legislation was used.

The safeguards

7.3. Under these proposals – before someone is reported for an offence and removed – it is intended that relevant individuals would be given a series of warnings about their behaviour or politely asked to leave the NHS premises. Only where they refuse to heed reasonable warnings about their behaviour, or polite requests to leave, would the options under this legislation be considered. In addition, those NHS health bodies that choose to exercise this power would be required to display clear signage in relevant areas of their premises and grounds, advising the public about the consequences of this type of behaviour and creating a strong deterrent for those who are minded to behave in this way. The aim is to have a strong message backed up by the means to

enforce that message, where it is appropriate to do so.

7.4. There may be circumstances where it will not be appropriate for the power to be used and strict safeguards will be built into the process to ensure that the powers are operated in a fair, objective and ethical manner. For example, it is suggested that those authorised to remove a person from NHS premises would be required to consult with an appropriate and relevant medical practitioner in certain circumstances, for example:

- if the person is – or thought to be – in need of medical treatment
- if the person is under or suspected to be under the influence of alcohol or drugs and cannot comprehend the impact/consequences of their behaviour, or if removal may harm their health and wellbeing
- if there are (or suspected to be) mental health or learning disability concerns, or if the person could be considered otherwise vulnerable, such as a child or an elderly person.

7.5. There may be other situations where use of the power would be inappropriate. For example:

- if the person's behaviour might have been caused by the receipt of distressing information
- if the person is exercising their right to complain in a fair and reasonable manner.

Exercising the power of removal

7.6. On the decision of the 'responsible person', removal would only ever be effected by security staff who have been specifically trained in physical intervention techniques to required competencies. It is proposed that this training would be based on elements of the [1]*Promoting Safer and Therapeutic Services* syllabus introduced by the NHS SMS in October 2005, along with a competency framework and guidance that will be issued by the National Institute for Mental Health in England (NIMHE) in 2006 for physical intervention techniques. This combination of training would give security staff the skills and expertise to safely and ethically remove individuals from NHS premises – when authorised to do so – with the minimum of force required.

7.7. No member of security staff would be expected to put themselves in a position that is likely to jeopardise their safety or security or that of others by removing someone who had been violent or who had

[1] Further information about *Promoting Safer and Therapeutic Services* can be found on the NHS CFSMS website at www.cfsms.nhs.uk

demonstrated a propensity for violence. They would be expected – as they are now – to request the assistance of the police in tackling and managing the situation.

7.8. Informal consultation with NHS health bodies suggests that the larger acute trusts would be likely to make use of the power to a greater extent than would PCTs and Mental Health Trusts, which may only remove a few individuals a year.

Questions

1. Do you agree that use of the powers should be authorised by a ‘responsible person’ designated by the chief executive of the health body?
2. What additional safeguards do you think will need to be put in place to ensure that these powers are operated in a fair, objective and ethical manner?
3. What sort of training do you think security staff removing nuisance individuals will need?
4. How often do you think the power of removal will be used?

8. Impact of use of the power of removal

8.1. Public authorities have a legal duty to promote race equality, which includes considering the impact that policies may have on people from different racial groups. There is little evidence to suggest that these proposals, if implemented in accordance with appropriate safeguards, would have an adverse impact on any particular minority group. However, available evidence does suggest that use of and satisfaction with the NHS can be affected by race, age, disability and gender, amongst other things. Therefore, an assessment of the impact of the proposals on a range of minority groups has been commenced and forms part of the consultation process (Annex A). This assessment is at an early stage and we would welcome comments on this generally, in addition to responses to the specific questions below. It is our firm intention to engage fully with those who represent these groups to consider what safeguards need to be put in place to ensure that no particular group is put at any disadvantage, along with how we should monitor the application of these powers in practice.

Questions

1. Do you think these proposals could adversely affect any particular group of society?
2. What safeguards do you think will need to be in place to prevent this from happening?
3. How should this be monitored?

9. Summary

9.1. It is believed that this legislation, along with the other measures that the NHS SMS has introduced, would help to prevent crime and therefore reduce the human and financial impact of crime in the NHS, along with tackling the consequences of the fear of crime. The proposals are designed to help free up resources for the delivery of high-quality healthcare that would otherwise be lost to the NHS. If introduced, these measures would also help to create a safer and more secure treatment environment for patients and a better working environment for staff. In addition, the creation of a power of removal may help prevent these incidents from escalating into more serious crimes, reducing the impact in the longer term on the police and Criminal Justice System.

10. Responding to consultation

Summary of questions

New legislation and what it might cover: offence of nuisance or disturbance behaviour on NHS healthcare premises and a power to remove such individuals from NHS healthcare premises

1. Do you agree that a new offence and power of removal is needed to deal with the problem of nuisance or disturbance behaviour on NHS healthcare premises?
2. Do you agree that section 547 of the Education Act 1996 (c.56) offence is a suitable model for use within the NHS?
3. Which types of behaviour should be covered?
4. Which types of NHS bodies and NHS premises should be covered by these proposals?
5. Is the proposed sanction appropriate and proportionate?

Authorising and exercising the power of removal

6. Do you agree that use of the powers should be authorised by a 'responsible person' designated by the chief executive of the health body?
7. What additional safeguards do you think will need to be put in place to ensure that these powers are operated in a fair, objective and ethical manner?
8. What sort of training do you think security staff removing nuisance individuals will need?
9. How often do you think the power of removal will be used?

Impact of use of the power of removal

10. Do you think these proposals could adversely affect any particular group of society?
11. What safeguards do you think will need to be in place to prevent this from happening?
12. How should this be monitored?

10.1. We aim to follow the Cabinet Office Code of Practice on Consultation (Annex B). This suggests a minimum period of 12 weeks for written consultation. We have also made extra efforts to ensure that the consultation is effective by supplementing the exercise with other methods of consultation. Relevant interested parties have already been informally consulted. The consultation will be widely publicised and every effort has been made to contact parties that may be affected by the proposals to ensure they have a chance to comment. Comments and other responses should be received no later than **1 September 2006**.

10.2. If responding in writing, please submit your views using the response form at Annex C, which includes details about yourself. If responding by e-mail, please ensure that you include the information contained in the response form in your message.

10.3. Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

10.4. If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information, we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, in itself, be regarded as binding on the Department.

10.5. The Department will process your personal data in accordance with the DPA and in the majority of circumstances this will mean that your personal data will not be disclosed to third parties.

You can send your views and comments by the following methods:

By post to:
Anna Quigley
NHS Security Management Service
Weston House
246 High Holborn
London
WC1V 7EX

By fax to: 020 7895 4600

By e-mail to: securitymanagementconsultation@cfsms.nhs.uk

The report about the consultation will be posted on the Department of Health's website (www.dh.gov.uk/consultations) within one month of the end of the consultation period.

Annex A

EQUALITY IMPACT ASSESSMENT

Policy aim: equipping NHS health bodies to deal with nuisance or disturbance behaviour on NHS healthcare premises.

1. Consideration of available data and research

The policy is a completely new initiative and therefore, it has not been possible to find evidence of the impact of similar policies. As a result, it has been necessary to make use of existing statistical data and other qualitative information on the use of and access to health services and the Criminal Justice System, both of which are relevant to the implementation of this policy.

If the policy is implemented, it is intended to design monitoring arrangements that will enable proper evaluation of its impact.

2. Assessment of impacts and consideration of measures

For an initial assessment of the potential impacts of the policy and consideration of mitigating factors, see the table below.

3. Formal consultation on the likely impact of proposed policies

Formal public consultation will commence on 10 June 2006 and will close on 1 September 2006. It will follow the Code of Practice on Consultation. In addition, extra effort has been made to ensure that the consultation is effective by supplementing the exercise with other methods of consultation. We have started this process by consulting widely with relevant interested parties, including Unison, the British Medical Association and the Royal College of Nursing. The consultation will be widely publicised and every effort will be made to contact parties who may be affected by the proposals.

This Equality Impact Assessment forms part of the consultation process. It is our firm intention to engage fully with those who represent these minority groups to consider what safeguards need to be put in place to ensure that no particular group is put at any disadvantage, along with how we should monitor the application of these powers in practice.

4. Decision

Once the consultation has been completed and the results analysed, the policy will be re-examined to decide whether it should be implemented, if there are alternatives that should be considered or whether any amendments should be made.

5. Publication of results of Equality Impact Assessment

The results of the Equality Impact Assessment will be published with a summary of responses to the consultation and the final Regulatory Impact Analysis on the Department of Health website.

6. Monitoring

The NHS SMS will provide a code of practice to ensure that the scheme is effectively implemented and assured. The responsibility to ensure that the policy is properly implemented at a local level will be that of the Security Management Director (SMD) and the LSMS, with central support and guidance from the NHS SMS. Monitoring to ensure that the measures have been effectively and properly implemented will be part of the NHS SMS quality assurance programme, which forms part of the Healthcare Commission's work on standards for healthcare.

Results from the monitoring of the implementation of the measures described in these proposals will be drawn together, analysed and reported on separately by the NHS SMS.

Category		Assessment of impacts		Consideration of mitigating measures and alternative policies
		Qualitative (detail evidence)	**Quantitative (detail evidence)**	
Impact Assessment	**Age**		1. Evidence shows that the over 65s make greater use of health services than do the rest of the population. Therefore, the policy could have both a positive and negative impact on this group. Through greater use of the services, a member of this group is more likely to be subject to the policy's implementation, but also more likely to benefit from its implementation and creation of a better treatment environment.	It is improper use of the policy and powers within it that could be discriminatory and is most likely to cause inequality amongst different groups. Therefore, it will be vital for the 'responsible person' making the decision as to whether an offence has been committed to have received extensive training so that they do not discriminate in carrying out their function. This training will include equality and diversity awareness sections as well as taking individuals through the steps to be followed before taking such a decision. A code of practice, covering all aspects of the policy, including its non-discriminatory use, will be drafted. Compliance with this will be monitored as part of the NHS SMS's quality assurance and inspection programme and its work on standards with the Healthcare Commission. In addition, training on physical intervention techniques for security staff will include an awareness of equality and diversity issues.

Category		Assessment of impacts		Consideration of mitigating measures and alternative policies
		Qualitative (detail evidence)	**Quantitative (detail evidence)**	
Impact Assessment	**Disability**	1. Impairments can make it difficult to access health services. It will be important not to exacerbate this problem by use of the power of removal. 2. The needs of this group will be significantly different from those of other users of the NHS. If these needs are misunderstood or not taken into account, the removal of a person could deny them necessary treatment. 3. The physical removal of a person will need to take account of that person's disability.	4. Evidence shows that disabled people make greater use of health services than do non-disabled people. See above.	It is improper use of the policy and powers within it that could be discriminatory and is most likely to cause inequality amongst different groups. Therefore, it will be vital for the 'responsible person' making the decision as to whether an offence has been committed to have received extensive training so that they do not discriminate in carrying out their function. This training will include equality and diversity awareness sections as well as taking individuals through the steps to be followed before taking such a decision. A code of practice, covering all aspects of the policy, including its non-discriminatory use, will be drafted. Compliance with this will be monitored as part of the NHS SMS's quality assurance and inspection programme and its work on standards with the Healthcare Commission. In addition, training on physical intervention techniques for security staff will include an awareness of equality and diversity issues.

Category		Assessment of impacts		Consideration of mitigating measures and alternative policies
		Qualitative (detail evidence)	**Quantitative (detail evidence)**	
Impact Assessment	**Ethnicity**	1. Research has suggested that healthcare staff are not sufficiently sensitive to the full range of racial, religious and linguistic diversity in the UK. Language and cultural differences will need to be taken into account by staff implementing the proposals. For example, a request to desist a particular type of behaviour may not be understood because of language barriers and taken as evidence to support removal.	2. Surveys show that people from ethnic minorities have lower levels of satisfaction with health services. Improper use of the policy or a perception of impropriety could exacerbate this problem. 3. Criminal Justice Statistics show that people from ethnic minorities are disproportionately represented in the Criminal Justice System. 4. Surveys also show that these groups are more likely to feel discriminated against on racial grounds.	It is improper use of the policy and powers within it that could be discriminatory and is most likely to cause inequality amongst different groups. Therefore, it will be vital for the 'responsible person' making the decision as to whether an offence has been committed to have received extensive training so that they do not discriminate in carrying out their function. This training will include equality and diversity awareness sections as well as taking individuals through the steps to be followed before taking such a decision. A code of practice, covering all aspects of the policy, including its non-discriminatory use, will be drafted. Compliance with this will be monitored as part of the NHS SMS's quality assurance and inspection programme and its work on standards with the Healthcare Commission. In addition, training on physical intervention techniques for security staff will include an awareness of equality and diversity issues.

Category		Assessment of impacts		Consideration of mitigating measures and alternative policies
		Qualitative (detail evidence)	**Quantitative (detail evidence)**	
Impact Assessment	**Faith**	1. Lack of awareness or understanding of different faiths can lead to discrimination. For example, the reasons for a dispute (where a patient's behaviour may be taken as unreasonable) may stem from a person's inability to attend an appointment on a certain day or at a certain time.		It is improper use of the policy and powers within it that could be discriminatory and is most likely to cause inequality amongst different groups. Therefore, it will be vital for the 'responsible person' making the decision as to whether an offence has been committed to have received extensive training so that they do not discriminate in carrying out their function. This training will include equality and diversity awareness sections as well as taking individuals through the steps to be followed before taking such a decision. A code of practice, covering all aspects of the policy, including its non-discriminatory use, will be drafted. Compliance with this will be monitored as part of the NHS SMS's quality assurance and inspection programme and its work on standards with the Healthcare Commission. In addition, training on physical intervention techniques for security staff will include an awareness of equality and diversity issues.

Category		Assessment of impacts		Consideration of mitigating measures and alternative policies
		Qualitative (detail evidence)	**Quantitative (detail evidence)**	
Impact Assessment	**Gender**	1. Staff effecting removal may need to take account of a person's gender.		It is improper use of the policy and powers within it that could be discriminatory and is most likely to cause inequality amongst different groups. Therefore, it will be vital for the 'responsible person' making the decision as to whether an offence has been committed to have received extensive training so that they do not discriminate in carrying out their function. This training will include equality and diversity awareness sections as well as taking individuals through the steps to be followed before taking such a decision. A code of practice, covering all aspects of the policy, including its non-discriminatory use, will be drafted. Compliance with this will be monitored as part of the NHS SMS's quality assurance and inspection programme and its work on standards with the Healthcare Commission. In addition, training on physical intervention techniques for security staff will include an awareness of equality and diversity issues.

Category		Assessment of impacts		Consideration of mitigating measures and alternative policies
		Qualitative (detail evidence)	**Quantitative (detail evidence)**	
Impact Assessment	**Human Rights**	1. Improper use of the policy could result in denial of access to treatment.		It is improper use of the policy and powers within it that could be discriminatory and is most likely to cause inequality amongst different groups. Therefore, it will be vital for the 'responsible person' making the decision as to whether an offence has been committed to have received extensive training so that they do not discriminate in carrying out their function. This training will include equality and diversity awareness sections as well as taking individuals through the steps to be followed before taking such a decision. A code of practice, covering all aspects of the policy, including its non-discriminatory use, will be drafted. Compliance with this will be monitored as part of the NHS SMS's quality assurance and inspection programme and its work on standards with the Healthcare Commission. In addition, training on physical intervention techniques for security staff will include an awareness of equality and diversity issues.

Category		Assessment of impacts		Consideration of mitigating measures and alternative policies
		Qualitative (detail evidence)	**Quantitative (detail evidence)**	
Impact Assessment	**Sexual Orientation**	1. Lack of awareness or understanding of sexual orientation could lead to discrimination.		It is improper use of the policy and powers within it that could be discriminatory and is most likely to cause inequality amongst different groups. Therefore, it will be vital for the 'responsible person' making the decision as to whether an offence has been committed to have received extensive training so that they do not discriminate in carrying out their function. This training will include equality and diversity awareness sections as well as taking individuals through the steps to be followed before taking such a decision. A code of practice, covering all aspects of the policy, including its non-discriminatory use, will be drafted. Compliance with this will be monitored as part of the NHS SMS's quality assurance and inspection programme and its work on standards with the Healthcare Commission. In addition, training on physical intervention techniques for security staff will include an awareness of equality and diversity issues.

Annex B

Criteria for consultation

When seeking views on our proposals, we follow the 'Cabinet Office Code of Practice on Consultation'. In particular, we aim to:

- consult widely, allowing a minimum of 12 weeks for written consultation during the development of the policy
- be clear about what our proposals are, who may be affected, what questions we want to ask and the timescale for responses
- ensure that our consultation is clear, concise and widely accessible
- ensure that we will give feedback regarding the responses received and how the consultation process influenced the policy
- monitor our effectiveness at consultation
- ensure our consultation follows better regulation best practice.

Comments or complaints should be directed to:

Steve Wells
Consultations Coordinator
Department of Health
Skipton House
80 London Road
London SE1 6LH

Email: steve.wells@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Annex C

PERSONAL DETAILS

Title	Mr/Mrs/Miss/Ms/Dr/Professor/other
First name(s)	
Surname	
Address	
Post code	
Email address	

IF YOU ARE REPLYING ON BEHALF OF A GROUP OR ORGANISATION:

Name of organisation	
Address (if different from above)	
Post code	
Email address	