The role of healthcare security: addressing key challenges

A report for the National Association for Healthcare Security (NAHS)

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Foreword

The National Association for Healthcare Security (NAHS) is a not-for-profit organisation dedicated to shaping strategy, providing professional support, and advancing the continuous professional development of those working in healthcare security. We welcome this research which demonstrates the key challenges facing healthcare security and draws on the views of professionals on how we as a specialist sector can move forward. We are committed to learning from these important insights, and in the absence of an official governance, audit and assurance structure for healthcare security we will continue our own work producing standards that can be used as a framework, and developing specialist training for frontline officers and security leaders to create a career pathway and consistency of approach. We will also continue to argue for Government backing for healthcare security standards to ensure healthcare organisations are obligated to give security the attention that it deserves.

We commissioned this report to understand the supporting evidence for our own aims as an organisation. As you read this report you will see that they closely complement them.

NAHS response to the research findings:

There is significant underinvestment or recognition at a local, regional, or national level of what healthcare security teams manage. Workstreams such as Right Care, Right Person, the Integrated Policing and Private Security Initiative, the Terrorism (Protection of Premises) Act 2025, SIA Business Assurance Scheme (Specialist Sector Approval in Healthcare), and the British Institute of Learning Disability Association of Certified Training which mandates the reduction in patient restrictive interventions, place even more responsibility on healthcare security Directors, Managers and Officers, meaning this lack of investment, understanding or regulatory support and oversight must change.

A regulatory / supervisory body (or bodies) is needed to oversee security management work in healthcare, to include:

- ⇒ *Pre-employment checks, initial and annual vetting of security personnel.*
- ⇒ *Healthcare specific education, training, and structured career development pathway. Designated key roles from Security Officer, Supervisor, Manager, Service Director, and Board Level Director (SRO). This must include joint training for security personnel, medics, and clinicians so there is a collective understanding and response to roles and responsibilities.*
- ⇒ *Appropriately qualified and experienced personnel to hold key positions with details retained by regulatory / supervisory bodies for each organisation.*
- ⇒ *Governance, audit, and assurance process with RAG rated standards which has an annual compliance return and audit process.*

- ⇒ *A national information and intelligence system to cascade critical information to key personnel (listed above).*
- ⇒ *Data analysis, annual returns, benchmarking of all security threats, vulnerabilities, and incidents to quantify the frequency and severity of incidents to determine workforce metric and financial costs.*
- ⇒ *Quarterly regional meetings and an annual conference to network with peers, share best practice, innovation, link with regulatory bodies and subject matter experts.*
- ⇒ *Security experts to oversee the development and procurement of security systems / physical security measures currently undertaken by Estates & Facilities Management and Procurement Teams, who have no expertise in security often resulting in the purchase of systems not fit for purpose and at significant unnecessary cost.*

Due to the complete breakdown in healthcare security governance, oversight and infrastructure, critical security workstreams such as counterterrorism and lockdown have been shoehorned into other protective services such as Emergency Planning Resilience and Response (EPRR) and Violence Prevention and Reduction which now sits as a separate and independent workstream. It must be recognised that if a counterterror incident occurred within a healthcare setting or a staff member was seriously physically or sexually assaulted, it would not be the EPRR or VPRS leads that responded, it would be the security team.

All the measures listed ceased to exist for healthcare security following the demise of NHS Protect in 2017. However, they remain in place for Emergency Planning, Resilience and Response (EPRR) and Counter Fraud (NHS Counter Fraud Authority), which cannot be justified.

The National Association for Healthcare Security (NAHS) has done a significant amount of work to address many of these gaps, but it cannot do it alone without government support.

Roger Ringham, Chair of NAHS

Acknowledgements

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Executive Summary

Healthcare is one of the most **complex** areas of security practice yet has typically been under-researched. Moreover, the **demise** of NHS Protect in 2017, and the gap that was created further fuelled an interest and need to explore current concerns, challenges and aspirations among healthcare security professionals. The research involved an online survey (122 responses) and (10) in-depth interviews with healthcare security professionals and those in other relevant key roles.

Key findings

Governance

A **lack of national steer** was the primary concern; respondents lamented the lack of leadership and guidance since the demise of NHS Protect. It was also apparent that this gap was not being compensated for at **organisation level** where there was a lack of senior level endorsement and support for security:

- 72% indicated there is a lack of clear national direction on expectations
- 48% indicated there is insufficient national collation/analysis of security incident data
- 42% indicated there was senior management support for security within their healthcare organisation
- 40% indicated there was a security strategy in place, endorsed at board level
- 37% indicated security is a standing agenda item at board-level

There was **considerable support** for all four specific suggestions posed for strengthening governance:

- 93% indicated there is a need for a **national** (healthcare security) **training and education pathway**
- 88% indicated there is a need for **national** healthcare security **standards**
- 85% indicated there is a need for **collation and dissemination of national incident data**
- 75% were in favour of an **annual audit and assurance framework**

Respondents highlighted that there was a need to **fill the gap** left by the demise of NHS Protect and that **mandating** the requirements and standards was the only way to ensure healthcare organisations prioritise security.

They also noted a need to **improve the way security is purchased** (and particularly security officers), improving specifications and focusing on quality to ensure that money is well spent and to achieve a better level of service, with an appropriate calibre of personnel that reflects the challenges of the role. Respondents also called for greater consistency in the skills of **security leaders** and to **elevate** their profile to be able to forge closer links with senior management and with clinical teams; there was a view security leaders should

become security **specialists** with appropriate training to **better articulate** how security **creates** a safer environment and thereby **enables** patient care.

Respondents also highlighted that the incoming **Martyn's Law** (The Terrorism (Protection of Premises) Act 2025) will impose legal requirements that will need to be considered by Boards and they hoped this would **elevate** the status of and interest in security, however this was **tempered** by concerns that the work will be allocated to Emergency Preparedness, Resilience and Response (EPRR) that will not be the first line responders to incidents (security teams will).

Recruitment and Retention

Recruitment was considered more (73%) of a **challenge** than retention (43%). In terms of the key factors posing a problem, **pay** edged ahead of the risk of violence and abuse, and recognition and advancement; although all the factors explored by the survey were noteworthy:

- 61% indicated the **pay relative to the threats and responsibilities** was a problem for recruitment/retention
- 51% indicated the (**lack of) recognition/respect** from the wider organisation
- 50% indicated the level of **violence** from patients/visitors
- 47% indicated **lack of advancement** opportunities
- 47% indicated the level of **abuse** from patients/visitors

Respondents also highlighted the **poor standard of applicants** as a key issue. They argued for a need to **review and revise the level of pay** (and the overall package) given the expectations and complexities of the role within healthcare. They also supported **creating a healthcare security career pathway** to help attract and retain security personnel. The issue of **probation periods** (some described these as not permitted by the NHS) reportedly made it difficult to remove poor quality candidates.

Operational issues

Issues relating to the challenges of **collaborating** with other departments and stakeholders (particularly the police) were a significant focal point; **resources** were also an issue:

- 69% indicated **inconsistent expectations** of security across departments
- 63% indicated a lack of shared understanding (between security and clinical staff) on the procedural limitations that govern the **use of restraint**
- 60% indicated a **lack of priority given by the police** to incidents (where a police response is required)
- 50% indicated there are **not enough security staff** within their organisation

In terms of the types of incidents faced by security, '**violence, aggression or abuse'** and **anti-social behaviour** were the incident types occurring most frequently within the respondents' healthcare organisation[1]:

- 81% indicated violence, aggression or abuse by **patients** occurred daily
- 44% indicated violence, aggression or abuse by **visitors/public** occurred daily
- 43% indicated anti-social behaviour occurred daily

Respondents highlighted the need for a **better understanding** among other departments (particularly clinical) **of the role of security** and the limitations they faced in lacking any special 'powers'. Moreover, that there should be a clinical 'lead' in situations where restraint is needed in a clinical context. They felt there is a need for a **clear approach (and training)** for work involving clinical staff and security **on the use of restraint** for **clinical** issues (e.g. mental health patients, dementia patients etc). They highlighted a need more generally to **address 'scope creep'** where security personnel are asked to cover tasks that they do not have the necessary accreditations/training/knowledge to safely carry out.

They also felt there was a need to **develop collaboration with the police** although views were **mixed** as to the best way of equipping/supporting security when a police response is lacking (some thought additional training, powers and/or equipment was needed; others were concerned that security personnel lack the ability to use these appropriately and/or that that type of response would not be appropriate to a healthcare environment).[2]

Unsurprisingly, respondents also noted the need for **greater investment** in security to **better reflect its importance, improve safety and be able to tackle key issues** such as violence and aggression. It was also suggested that the **staffing model adopted** (i.e. in-house or contracted) and the relative pros and cons required further consideration.

Training

There were **very high** levels of agreement on proposed ways of **improving training**, suggesting that addressing training is a **clear area for attention**:

- 92% indicated that there should be **healthcare specific** security training for **all** security personnel
- 90% indicated there should be a **joint approach** (and training) to restraint
- 90% indicated there is a need for **Government endorsement** of healthcare security training
- 90% indicated there is a need for a **nationally recognised training framework**

[1] There is no consistency of approach and NHS responsibility for Violence Prevention and Reduction may be allocated to clinical staff, to security or to an independent lead.
[2] Current work under 'Right Care, Right Person' and the 'Integrated Policing and Private Security Initiative' (IPPS) is developing the approach to collaboration.

Clearly, there was widespread support for specialist healthcare security training via a **national, mandatory model**.[3] A number of respondents noted they were in favour of a specific healthcare security **SIA licence**.[4]

There was a specific call for **consistency in training on restraint techniques** – it was cautioned that at present different models are taught (even among SIA licensed operatives) and that this creates risks that two individuals may attempt to apply different techniques at the same time when working together. Further, the need that the techniques adopted are not just consistent but are **appropriate to clinical contexts** was flagged.[5]

There was emphasis on specific skills needed within specialist healthcare training, particularly **clinical awareness, communication skills, de-escalation skills** (so physical intervention is an exception/last resort), relevant **legislation**, and **counter terror** awareness.

What next?

This research has demonstrated that the gap left by the demise of NHS Protect not only **remains**, but is **significant**, and the consequences are **far reaching**. According to our sample, healthcare security has been **neglected**, **misunderstood** and **attracted unwelcome criticism** based on a misunderstanding of its role and responsibilities. The research has highlighted a number of actions that are needed to **better position** healthcare security to meet the **significant demands** of operating in healthcare environments and to re-frame security within healthcare organisations as an **enabler of patient care**. Respondents called in particular for: a **national governance structure** to oversee security and set the standards – this would help address many of the challenges identified; a **nationally recognised healthcare specific training framework** for security to ensure all personnel at all levels are trained appropriately for the specialist nature of their work; **direction on how to better engage with the police** and how to manage when the police are unable to respond; and **appropriate investment** in security – paying personnel appropriately for the challenges of the role, and developing a better approach to buying security so that resources are used to optimum effect.

[3] In the absence of a mandatory model, NAHS has developed Level 1 - 3 healthcare specific Security Officer and Level 5 healthcare specific Security Manager / Director training.
[4] The SIA are developing their Business Assurance Scheme to replace the Approved Contractor Scheme. Healthcare is listed as one of the five specialisms for security organisations to aspire to. NAHS and the BILD ACT Restrictive Interventions network are contributing feedback on the design.
[5] The British institute of Learning Disability (BILD) Association of Certified Training (ACT), through the Mental Health (Use of Force) Act 2018, has developed accredited training relating to restrictive interventions. This was initially launched in Mental Health but version 2 will relate to acute, healthcare security, ambulance and secure transport.

Table of Contents

Executive Summary 6

Section 1. Introduction 11

The context to the research 11

Presenting the findings 12

Section 2. Governance 13

The current state of governance 13

Addressing the weaknesses in governance 16

The governance gap 16

The features needed in a national governance structure 18

Elevating security leadership 23

The impact of the incoming Martyn's Law 26

Section 3. Recruitment and retention of security personnel 30

The factors impacting on recruitment and retention 30

Addressing the recruitment and retention challenges 35

The package, particularly pay 36

Creating a specialism and a 'career' 40

Section 4. Operational issues 42

The key operational challenges 42

Occurrence of security-related incidents 45

Addressing the operational challenges 47

Clarifying the role of security 47

Improving collaboration with the police 54

Properly resourcing security 61

Section 5. Training 66

Possible mechanisms for strengthening training 66

Key considerations for developing the training 67

One national, mandatory model 67

Consistent restraint techniques 71

Other knowledge and skills to be covered by training 72

Section 6. Discussion 76

What does all this mean? 76

What is required? 77

A national governance structure 77

Nationally recognised healthcare specific training framework 77

Engaging with the Police and managing without them 78

Staffing security 78

Appendix 1 – Methods 80

About Perpetuity Research 83

Section 1. Introduction

The context to the research

1.1 The role of security personnel, from frontline workers to directors, has undergone transformational change in recent years. In some domains there has been focused research to assess trends and attitudes of workers towards them, but in others, and healthcare is one, research has been sparse.

1.2 Indeed, since the demise of NHS Protect in 2017, healthcare security has operated somewhat under the radar, without an established governance framework supported by standards and training, and without any focus on systematically understanding the factors that are impacting on healthcare security personnel and healthcare security practice.

1.3 Yet, healthcare security is one of the most complex areas of security practice. Healthcare environments in the UK encompass a diverse range of settings and varied challenges, not least open-access areas, diverse stakeholders, emergency life-critical care and associated high emotional intensity. Security in this context is protecting property, enforcing compliance, safeguarding people, data and physical infrastructure, whilst also balancing security needs with clinical priorities, patient rights and dignity, and legal and ethical concerns. Managing the interplay between these various factors creates a uniquely challenging security environment.

1.4 Moreover, in the UK, healthcare is a heavily regulated sector in order to manage risk and ensure patient safety and standards of care, and security must operate within this context. The private security industry is itself regulated by the Security Industry Authority (SIA) for 'licensable' roles, but this is not universal given the exemption for 'in-house' security personnel, and that security business licensing is voluntary (although both issues are currently the subject of UK government consultation).

1.5 The purpose of the research was therefore, to consult with those working within healthcare security and other related roles/interests to establish current concerns, challenges and aspirations, and to start to consider how the approach to security could evolve. Ultimately, the intention was to provide an evidence base that could be used to inform the aims of NAHS with respect to shaping strategy, providing professional support and advancing professional development within healthcare security.

Presenting the findings

1.6 An overview of the findings from a survey (122 responses) and in-depth interviews (x10) with healthcare security personnel (and those in related roles/interests) is presented below. While it is acknowledged that many issues are interlinked, for clarity, the findings have been organised into four sections, each addressing a specific theme:

- Governance
- Recruitment and retention of security personnel
- Operational issues & occurrence of incidents
- Training

1.7 The findings are then followed by a discussion of the key issues. Details of the methodology and survey sample can be found in Appendix 1.

Section 2. Governance

2.1 As noted at the outset of the report, since the demise of NHS Protect, there has been no governance framework for healthcare security within the NHS, creating the potential for a lack of suitable oversight, a limited understanding of (and therefore response to) the key threats and a lack of integration and collaboration with other departments. Survey respondents were therefore asked about how security is overseen in their own organisation as well as the actions needed to strengthen governance of healthcare security.

The current state of governance

2.2 Survey respondents were presented with a number of statements designed to gauge their experience of and views on the strength of governance and oversight of healthcare security.

2.3 Here, a **lack of national steer** appeared to be the **primary** concern.

2.4 Close to three quarters (72%) of respondents agreed or strongly agreed that *there is a **lack of clear national direction** on what is expected of healthcare organisations in relation to security* (indeed, of this figure, 49% had **strongly** agreed) suggesting that this is the **standout** issue in respect of governance. Only 5% of respondents disagreed or strongly disagreed with the statement (and 21% gave a neutral response).

2.5 Further, close to half of respondents (48%) **disagreed** or strongly disagreed *that **sufficient data** on security-related incidents[6] is **collated centrally** to give a national perspective on trends and ongoing threats* (26% were neutral on the matter, and 26% thought there was sufficient collation).[7]

2.6 At an **organisation level** respondents' views also indicate a **lack** of governance. Only around two fifths (~40%) of respondents agreed or strongly agreed that:

- security is a standing agenda item at **board** level (37%)
- there is a meaningful security strategy **endorsed** at board level (40%)
- security threats are reflected in **assurance** frameworks / governance registers (40%)
- senior management **proactively support** security (42%)
- the Violence Prevention and Reduction Standard (VPRS) or equivalent is adhered to (43%)

[6] For 'security-related incidents' we gave the examples: verbal abuse, violence, acquisitive crime, possession of prohibited items, intruders, vandalism, absconding, offences against the person etc.)
[7] No national data is collated on the Violence Prevention and Reduction Standard or on security incidents, and therefore those indicating there is sufficient collation may be indicating that they see their own monitoring as sufficient to inform them, without a need for national data.

2.7 Only half thought there is *good collaboration between security and non-clinical departments*[8] (51%), and *between security and clinical departments* (46%), which is striking given the frequency of incidents involving violence and aggression against staff highlighted subsequently (see Section 4 below, para 4.9).[9]

2.8 Three-fifths (61%) of respondents indicated that their **procedures** are regularly reviewed and updated; clearly here too, there is room for improvement to make certain that procedures take account of evolving threats and vulnerabilities.

2.9 Just under two-thirds (63%) indicated that the person they *directly report to was able to influence/implement change (in respect of security-related practice/ issues)*.

2.10 The full list of statements and the level of agreement/disagreement are displayed in Table 1, with the 'national' factors in blue text, and the 'organisation' level issues in black text.

[8] For 'non-clinical departments' we gave the examples: estates, facilities management, procurement etc.)
[9] See also Section 4, para 4.19 for further discussion on the lack of clarity between clinical and security staff in respect of dealing with clinical related violence and aggression.

Table 1: Governance issues ordered by level of concern (n=100 to 104) %

Issue	Agree / Strongly agree	Neutral	Disagree / Strongly Disagree
There is a lack of clear **national** direction on what is expected of healthcare organisations in relation to security	72%	21%	5%
Sufficient data on security-related incidents is collated centrally to give a **national** perspective on trends and ongoing threats	26%	26%	48%
Security is included as a standing agenda item in board-level (or equivalent) meetings (within my organisation)	37%	30%	33%
We have a comprehensive and up-to-date security strategy that has been endorsed and approved at board level	40%	27%	33%
The organisation's security threats are clearly reflected in assurance frameworks or corporate governance registers	40%	37%	23%
Senior management at my healthcare organisation proactively support security	42%	33%	25%
The organisation adheres to the Violence Prevention and Reduction Standard (VPRS), or equivalent, to support a safe working environment	43%	34%	34%
There is good collaboration between the security team and clinical departments at my organisation	46%	36%	18%
There is good collaboration between the security team and non-clinical departments at my organisation	51%	33%	16%
Our security procedures are regularly reviewed and reflect changing threats and vulnerabilities	61%	25%	14%
The person I directly report to is able to influence/implement change (in respect of security-related practice/ issues)	63%	21%	16%

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Addressing the weaknesses in governance

2.11 Respondents were asked to indicate which potential changes would **strengthen** the governance and oversight of security; they could tick all that apply. There was considerable support for all four suggestions posed:

- 93% supported a *national **training and education pathway** for healthcare security personnel*
- 88% supported ***national** healthcare security **standards** to sit across both primary and secondary care*
- 85% supported *collation and dissemination of **national data** to identify existing and potential threats and vulnerabilities*
- 75% supported ***an annual audit and assurance framework** to ensure compliance and consistency of approach*

2.12 In open comments within the survey and within the interviews, respondents elaborated on what they considered to be the key issues in respect of governance that needed to be addressed. The **gap** left by the demise of NHS Protect; the **features** that should be included in a governance structure; and the need to **elevate** security leadership to a stronger position within healthcare organisations, received the most attention and are therefore now considered in turn.

The governance gap

2.13 A number of respondents **confirmed that the removal of NHS Protect has left a gap** in governing the approach to security within the NHS and there was a strong view, in line with the survey findings above, that this gap needs to be filled by a **national steer**:

> *'It is crazy that the NHS Standard Contract makes reference to no smoking policies, green transport and fraud, but nothing on security. It is beyond criminal that the largest employer in the UK with a budget in the region of £200bn has no security strategy or national framework or obligations on NHS organisations.'*
>
> *(Survey respondent)*

> *'.. a lack of strategic direction from the NHS. When you go back to NHS protect and core standards – that lays out the expectations of what a security function should do. That hasn't existed since 2017 so there isn't that strategic oversight.'*
>
> *(Interviewee 9 – in-house security lead)*

> *'Since NHS Protect was disbanded there is no longer any requirement for Trusts to employ security staff, to have a Security Management Director or Head of Security. This is*

a glaring gap for the provision of security in healthcare settings.'

(Survey respondent)

'Since the demise of NHS Protect there is a desperate need for a national body to give direction and oversight of NHS Security Management and all that entails. Secretary of State Directions are still pertinent but no body to guide and enforce them!!! Standards need to be realistic and achievable, not sure the current VPRS standards are realistic or achievable in their entirety??'[10]

(Survey respondent)

'Previously there was NHS Protect. It wasn't perfect but it was something. Now there's nothing. It's created this siloed approach. Each trust doing its own thing. The experience and outcomes can vary from trust to trust.'

(Interviewee 1 – in-house security lead)

'Security impacts every part of healthcare and yet we remain without national guidance and strategy, since the demise of NHS Protect.'

(Survey respondent)

'There is no direction. No governance assurance process at all. No sharing of intelligence. There is no consistency of approach even though we deal with the vulnerable. No benchmarking. Take the NHS New Hospital Programme, and this is supposed to be the footprint, and after they had done their work at that point, they looked at security, and I have been to a meeting, and I was the only person who knew about physical security. There has been no input before that. So, security, of any sort, at any level, has been excluded. How naive and frightening.'

(Interviewee 4 – in-house security lead)

'Complete lack of understanding and support for VPRS standards. Rolled out without any clear support network. Leaving organisations to muddle through.'

(Survey Respondent)

There needs to be some governance – there are multiple critical risks in healthcare security.

(Interviewee 3 – contract security management)

2.14 A few advocated bringing NHS Protect (or similar) back:

'How about we go back to the good old days of NHS Protect for physical security. We only missed it when it was gone!'

(Survey respondent)

[10] It should be noted the Violence Prevention and Reduction Standards (VPRS) is a stand-alone workstream and is not integrated with security, albeit some organisations may assign actions to security management.

'Bring back NHS Protect!'

(Survey respondent)

'We should consider an NHS Protect approach. This was a good benchmark for security services before being decommissioned.'

(Survey respondent)

The features needed in a national governance structure

2.15 Some respondents emphasised their view that **mandating** the approach to security was the only way to ensure it is **prioritised**, otherwise security would never receive sufficient attention:

The problem with NHS Security is that nothing is mandated or statutory - therefore always fighting for funding and improvements. if something is not mandated, particularly when it's seen as "non-clinical", Trusts tend to regard security as not that important....until something goes catastrophically wrong.

(Survey respondent)

'There should be something because in an NHS environment if they don't have to do something they won't do it. It needs to apply NHS and CQC[11]. NHS orgs are scared to death of CQC. A couple of KPIs – that would drive security.'

(Interviewee 10 – contract security management)

If anybody struggles financially, the things they get rid of is the things they don't have to do by law. Security is often where cuts are made.'

(Interviewee 8 – other security expert)

Security is not high enough up on the governance structure to get the interest or investment it should have. Partly, the security sectors problem because the heads of security aren't the best at shouting up and pushing things.'

(Interviewee 6 – other security expert)

'In the local remit it comes down to where you (security) sit. I sit in Estates which is under Finance, I'm well established and well known, therefore, I am able to escalate things - board reports – risk structures. The Trust is bombarded by constraint and security doesn't have a high profile. It needs standards or something that says security is a primary role, and this is what you need to do. Organisations would then abide by that. At the moment it won't move forward, it will sink lower – like portering – if there is an incident security will be called – otherwise it won't rise up and its true value won't be ever seen – it's very disheartening.

(Interviewee 5 – in-house security lead)

[11] Care Quality Commission

'Introduction of NHS England security standards, following full consultation with those running the security management services across healthcare.

(Survey respondent)

2.16 Some respondents elaborated on the aspects that they felt needed to be covered by a national approach, such as **agreed processes with organisations such as the police**, on **expenditure**, on security **staffing structures and job descriptions**, on the **scope** of the role such as what types of incidents security should (and shouldn't) be dealing with, on specific areas such as **counterterrorism** and crime reduction, on ensuring recommendations (e.g. following a significant failure) have been **implemented**, and on **training**:

'The Government need to look at strengthening policy and procedures with other public institutions such as the Police to ensure we have a focused procedure for the protection of NHS staff, we also need to look at expenditure and consider how contracts are maintained within the NHS through PRI wastage, we need a national steer for security within the NHS regarding Job Descriptions training (restraint) CRT to ensure the NHS isn't wasting further expenditure on services that do not fit the bill! The military model of training instructor wing with a national steer would be a perfect solution including the reintroduction of a single nationally accredited course for the LSMS remit.'

(Survey respondent)

'A national recognised MOU with local police forces so that police response and criminal investigation protocols are agreed and fully implemented as part of any new security management standards.'

(Survey Respondent)

'The NHS need a national stance on security including strategy, standards, risk assessments, training. This would align all acute trust to the same standards.'

(Survey respondent)

'The role needs national accreditations, operational standards, and management pathways. Money should be ringfenced year on year.'

(Survey respondent)

'Clear central NHS direction on Security function, role and response. Clear position on if and when Security staff should be dealing with patients / in patient v ED/outpatients etc. A national lead and review on creation of a central function for security staffing, counterterrorism, physical security, NHS crime reduction.'

(Survey respondent)

'When something does go catastrophically wrong in a Trust and national recommendations are made, there is no stringent follow up to ensure recommendations have been

implemented. also, there is no formal mechanism to share best practice widely and rapidly.'

(Survey respondent)

'It needs to be professional, have teeth, have expertise. It shouldn't be private companies. It should be an in-house model. In a universe where I was the head of that body, I would have fixed roles to ensure all assets are being dealt with, so it's not left to one person to spin those plates. But there will be trusts that can't afford that. Smaller trusts that couldn't justify replicating that.'

(Interviewee 1 – in-house security lead)

'We need a set of standards signed by Parliament or included in the NHS Contract, that you need to do then be aware of the risks. Adopt a strategy which needs to be mandatory and accountable and audited, so the trust is held accountable. And the only way to do that is with financial accountability – anything less, then it will be swept under the carpet. We need someone in Parliament on board.'

(Interviewee 5 – in-house security lead)

'It needs the NHS to sign up to an in-house standard – a charter – whatever it's going to need to become – how expect security to be delivered. That ties in to how suppliers operate.'

(Interviewee 3 – contract security management)

2.17 Some specifically noted a need for a consistent (and better) approach to **buying security**. There were concerns at a **lack of security input** and a **lack of understanding of needs**, that results in prioritising (low) cost over quality, and **misses opportunities** to develop a better service or simply to spend money more appropriately:

'Irresponsible buyers. Trusts are irresponsible how they go through the tender process. Why have people involved that have no knowledge. The problem is when they let the accountants loose. It's a race to the bottom. As an industry we need to kill that. They want the cheapest.'

(Interviewee 2 – contract security management)

'We deal with a lot of input-based specs. Sell something we've been asked. Why not output spec. These are our problems, what can you design for it. The tender is the wrong way round and you are set up to fail in the KPIs. Then there are the innocuous tasks that won't get done. We need to change the tendering process. What can you do to help us meet this and build that contract together.'

(Interviewee 3 – contract security management)

'Some contracts are 20 years old, and they have been renewed and they haven't done the necessary change notifications. The bidding process – NHS sub-contract to organisations like [3rd party organisation], that's one we

keep seeing, who ask for the same thing in each bid. The people doing the tender aren't close to the reality.'

(Interviewee 3 – contract security management)

'Estates and Facilities management procure security measures and yet they mostly don't consult security and are not required to do so. Mostly in Trusts it is facility managers and procurement who decide, and so contracts are not fit for purpose. This happens across the NHS. Security managers do not have the authority to be in these discussions. People have their own little Empires and often don't want to relinquish titles and budgets because it impacts them. Even capital projects will be asked to fund, and they will do the same and that adds another non-security element into buying decisions about security.'

(Interviewee 4 – in-house security lead)

2.18 A few respondents noted that there is already oversight for **EPRR** (Emergency Preparedness, Resilience and Response) within the NHS, and that security should be treated in a similar way. Another noted that there is a national authority for counter fraud:

'The issue is a complete lack of governance across the NHS. Compare how security functions are overseen with EPRR. The very first thing in terms of core standards for EPRR relates to governance – there must be an AEO (accountable emergency officer) and that is a board level person with direct responsibility for ensuring EPRR policies and procedures are fit for purpose. There is nothing like that for security. The NHS understand governance but where security is concerned it's thin to non-existent. They only need to mirror the approach to EPRR. If they get that right – everything will fall into place.

(Interviewee 9 – in-house security lead)

'I can't see that it would be a disadvantage if there was a body that has more sway with the trusts. There is a senior EPRR in trusts but not for security.'

(Interviewee 1 – in-house security lead)

'I supply counter fraud. They have a national authority in this area like NHS Protect. Emergency Planning also have a national structure. Only security do not.'

(Interviewee 4 – in-house security lead)

2.19 One survey respondent warned that as part of determining a national approach, stronger links were needed between physical and **cyber** security:

'[There is a need for] the development of strong links between physical security and cyber security - this has been evolving in the corporate sector for the last 20 years, but I think the NHS is behind the curve on this.'

(Survey respondent)

2.20 It was also highlighted that there is a need for a clear understanding of the **diverse** range of healthcare settings and that any structure needed to recognise and reflect variation:

> *'There is not a one-size-fits-all approach here. For instance, as we have only one or two physical assaults each year that could be considered criminal, the VPRS are not relevant to our Trust.'*
>
> *(Survey Respondent)*

> *'There's the challenge of what is special about healthcare – a hospital, general A&E is different to a mental health trust or a secure unit trust. Different settings and different skills exercised.*
>
> *(Interviewee 7 – other security expert)*

2.21 One interviewee suggested an alternative to move things forward in the absence of a full structure would be to develop a **BSI standard** for Healthcare Security (further thoughts on training standards are dealt with separately under the subsequent 'Training' section of this report – see Section 5) to at least help set a standard for security officers and the scope of the role:

> *'There is a solution, but it is a plaster. Approach BSI and ask for a British Standard for Healthcare security to be developed. Healthcare security operates under the British Standard for manned guarding. Let's go down that route – have that as part of the ACS accreditation – that gets added into your scope of accreditation. At least that way there's reassurance that there's an understanding from the business deploying the officers in the Trust to operate in accordance with the standard. If you do it with BSI, that's easier than a whole industry scheme. If we started today, it could be done and introduced in six months and talk about uniform, training standards, sales of service – deliver what you've sold – don't under-deliver and don't be over-burdened.'*
>
> *(Interviewee 2 – contract security management)*

2.22 Some noted the value of a mechanism for **sharing good practice**:

> *'I often to talk to other security managers in [one region] and we do all seem to have the same type of issues. we have jokingly agreed it our therapy session!!'*
>
> *(Survey Respondent)*

> *'Sharing best practice, reinstate regional and national meetings (as previous LSMS).'*
>
> *(Survey Respondent)*

> *'Networking support is critical; we're all working in silos and that's not a good place to be. NAHS – if it filled the position of NHS Protect and in the same framework would be good. We need access to a national alert system – we have no*

framework to do that – how are things notified, retained, archived? We need a number of "must do's" under a framework which would make it much easier to do our job – we would just pull it off a shelf and those policies would be there.'

(Interviewee 5 – in-house security lead)

2.23 In respect of **data**, and the suggestion in the survey for collecting incident data centrally, one survey respondent highlighted the need to identify **individuals** posing **recurrent** problems for healthcare:

'Database established to identify serial offenders and those most likely to try bed hopping.'

(Survey Respondent)

Elevating security leadership

2.24 Respondents also specifically highlighted the **importance** of the in-house security leadership.

2.25 There were criticisms that at present **some managers lacked the knowledge and skills required** which limits performance. This was not intended to be a criticism of the individuals, rather that organisations lack an understanding of what is needed and therefore do not select or train individuals appropriately:

'Change of management - people who have experience and leadership skills in the required field.'

(Survey respondent)

'Ensure there is an accreditation for managers employed in a security function within the NHS.'

(Survey respondent)

'If the management layer fails to understand security risk management, then this will cascade downwards, resulting in poor provision for security staff.'

(Survey respondent)

'The clients that we've got – the FMs and LSMS is a joke. Several have no security background - no understanding of how to achieve security. One LSMS used to be a receptionist – and I asked how she got into it, and she said she was told she had to be the LSMS. She doesn't even want to do it.'

(Interviewee 2 – contract security management)

2.26 Respondents noted a need for **greater consistency** in the skills in security leadership across NHS Trusts, with **specialists** (rather than generalists managing various functions), with **appropriate training and qualifications**, to **better reflect and advocate for the status that security should hold**:

'Certainly, within acute Trusts, Head of Security posts should be recognised as a Corporate Senior Manager and

there should be a minimum AfC[12] Banding, e.g. 8B, so that the role has visibility at senior and executive levels. Heads of Security/Security Managers at Band 6/7 is not good enough.'

(Survey Respondent)

'Mandatory role for NHS Trusts, i.e. Head of Security, Security Management Director.'

(Survey Respondent)

'Security will only be strong within NHS trusts when security managers have actual qualifications at a degree level that demonstrate competence and capability. The use of poor-level in-house qualifications, does little to enhance this and represents a siloed mentality that provides little in the way of value-added skills.'

(Survey Respondent)

'The most senior person with any knowledge of security sits with Head of Security – is really a middle manager and they usually report to the Facilities Director, who has no understanding of the role. So if you don't have a strong and influential Head of Security the ability to get funds and deliver service falls by the wayside.'

(Interviewee 6 – other security expert)

'We [supplier company] support and guide our teams to do it properly and consistently. It is like herding cats in healthcare. It can be herding horses in other sectors, but it's herding cats in healthcare. Managers are not security professionals, they may be quadruple hat-ted, some are waste and portering and other things as well as security.'

(Interviewee 3 – contract security management)

'In my organisation, security is often part of a wider remit of logistics and other roles, which are often the primary focus of the security manager, which increases the challenge in recruiting people to the role and in retaining them when they have other opportunities for progression based on their other skills.'

(Survey respondent)

'Security is failing within the wider NHS through an inability to realign to security being a key leader in operational risk management, able to elocute and articulate risk management and how risk impacts service delivery. Too many security managers lack skills and are in post simply because they are a former police officer, with a focus on policing skills, not security management skills.

(Survey respondent)

'We definitely need it legitimised – security needs a profile and doesn't have this at the moment. When I came to this trust, people thought I was ex-police with a pocket full of

[12] Agenda for Change

keys. Certain individuals who join security think it's the same place as they've just left … it's the people element they don't have, that care and compassion and it's that balance they need.'

(Interviewee 5 – in-house security lead)

2.27 Some lamented that the **Local Security Management Specialist (LSMS)** model (which included training) was no longer used as it had provided a consistent standard, but others thought that the LSMS model was outdated and that there is a need, at least in some environments, to have a number of security leaders with specific specialisms and focuses/responsibilities:

'There used to be LSMS training – local management – I did that – I loved it. The skills it gave me was second to none. To find out a few years later that we wouldn't have it.

(Interviewee 10 – contract security management)

'There is also the leadership of the security function. If you go back to the days of the LSMS qualification and a set standard of security manager, then that leads to set expectations among the team. I have worked in security and also in emergency planning. If you compare security to emergency planning - there is a level 4 DIPHep, and that qualification is taught irrespective. That one-year qualification is consistent to all of you. That sets the standard there. But there is nothing like that for security.'

(Interviewee 9 – in-house security lead)

'[previously the security structure] was leaning on the outdated 'LSMS' model which is let's have a massive trust that deals with millions of patients, thousands of staff and over a hundred football pitches worth of sites, and to manage that lets have one person – a security specialist and tell them to spin every plate.'

(Interviewee 1 – in-house security lead)

2.28 One interviewee (an in-house security lead) noted their organisation now has a security management team with leads for different aspects. They highlighted that as a result of the changes they are getting positive feedback from the organisation and the police for their approach and are being celebrated within the organisation for the progress they have made.

2.29 That interviewee felt that recruiting security leaders from outside of healthcare/NHS had been beneficial in gaining support and respect from senior leaders:

'If our team had only worked in the NHS and worked their way up, then they maybe wouldn't listen as much [because they would not be seen as security experts]. We are productive in assessing the risks and collaborating with

outside agencies, so it isn't just us [saying what is needed for security]. The counter terror officers are saying we need to do this. It's not just us saying this would be good.'

(Interviewee 1 – in-house security lead)

The impact of the incoming Martyn's Law

2.30 A number of survey respondents and interviewees highlighted the significance of the incoming[13] Martyn's Law [officially titled the 'Terrorism (Protection of Premises) Act 2025'] to healthcare security, and here there were a number of considerations.

2.31 First was the **need to prepare**, and this was seen as something that would require collaboration with others, and where a national steer would be helpful:

'Counter terrorism, we need to do more within NHS organisations due to new and emerging threats within the UK, (home grown).'

(Survey respondent)

'Martyn's law as well.'

(Interviewee 7 – other security expert)

'There is over reliance on technology. With Martyn's Law we need boots on the ground.'

(Interviewee 2 – contract security management)

'Collaborative working with EPRR leaders to meet the Protection of Premises Bill requirements i.e. standard and enhanced tiers.'

(Survey respondent)

2.32 Second was the view that because Martyn's Law created a **requirement to act** this would put a focus on the importance of security that had been lacking since the demise of NHS Protect:

'The way NHS respond to Martyn's law will be very telling as to how seriously [healthcare organisations] take their responsibilities. They will need to nominate a board level person to ensure the correct writing of evacuation and invacuation plans etc. There will be a need from that. It will be interesting to see the way the NHS respond to that.'

(Interviewee 9 – in-house security lead)

'Now with the new legislation that's coming in, it is getting results.'

(Interviewee 1 – in-house security lead)

'The only saving grace is with Martyn's Law if any of the Trusts fall into the advance tier or regardless – there needs to be a nominated person to be registered and needs to be

[13] At the time of writing, Martyn's Law had received Royal Assent on 3rd April 2025, with enforcement expected to begin around Spring 2027 following a 24 month implementation period.

executive level etc. Then if that was going to be me, I'd want to make sure my Trust has invested well enough, so if visited by regulators, we would be confident we could show the counter measures in place to keep people safe, especially from an evacuation and lockdown procedures. Only way you'll get interest 1. If reputation is going to be tarnished 2. Need to do it.'

(Interviewee 6 – other security expert)

'Martyn's law will change some of that. It is recommendation until March 2027. The stakes are high. The chair – the CEOs are accountable, not the security guard at the door. This legislation is on a par with Health & Safety.'

(Interviewee 8 – other security expert)

2.33 One interviewee was concerned that the current structures and lack of acknowledgement of security departments, meant that meeting the Martyn's Law requirements will sit with the **'wrong' people**, and not have sufficient input from security, yet security would be the ones responding to such incidents:

'Martyn's Law, healthcare is named, enhanced tier will be acute hospital, and healthcare is named as a public area. SIA will audit for security. But in healthcare, the service responsible for developing the response in Trusts is EPRR, Emergency Planning Resilience and Response, it manages Martyn's Law for Trusts, even though EPRR won't deal with a bomb nor will Estates, it will be security. So areas with no experience of security are doing something they don't understand and often not involving security in the process.'

(Interviewee 4 – in-house security lead)

2.34 One interviewee noted the importance of training and advocated for **lower tier organisations to undertake ACT training** even though it will not be mandatory for the lower tier under Martyn's Law[14]:

'It is available free of charge on the Protect UK website. All it would cost is 1 hour staff wages. How would people know what to do to protect themselves if they don't understand the threat?'

(Interviewee 8 – other security expert)

2.35 They highlighted the **dangers of complacency**, including among the smaller healthcare organisations:

'To me the biggest issue is that people do not go complacent, don't think [the organisation is] not big enough, we are only small. Terrorists do not care. They

[14] It is also notable that while the NHS mandates PREVENT training for staff (to identify, refer and support individuals vulnerable to radicalisation), there is currently no requirement to undertake ACT, SCaN or 'Run, Hide, Tell' training.

look at people as numbers. Even a small surgery – if there are 20 people – that's 20 they can kill. A terrorist attack isn't taking 10 hours to unfold. They don't just pick up a knife and do it, they go on the dark web, and they learn where to strike to make it fatal, where the key arteries are. They train themselves up and can dish out fatal blows in seconds. There is not the luxury of time to escape.'

(Interviewee 8 – other security expert)

2.36 One interviewee highlighted the very challenging nature of **lockdowns** and noted that there will be a lot of (valuable) work to do to engage with staff on complex sites, to ensure effective procedures are in place to meet the requirements of Martyn's Law. They suggested having a **governing body to steer the approach** would be beneficial, and they talked about their own plans (an 'inside-out' approach) and the need to create a channel for **mass communications**:

'Lockdowns are a problem. That's a massive challenge in the NHS. We invite everyone in. It's hard to lock down. Even with plans in place, it's difficult to achieve. If we did have a body, an overarching body that could set out what is needed to overcome the difficulties, how to approach this. There's a huge amount of entrances and exits, miles of corridors. The plans have relied on an outside-in approach. I don't think that would be effective, it would be too late. I plan to do it inside-out, to put the onus on managers and departments to lockdown their areas because they are specialists of their areas. Where are the keys, what is your ward layout, these are your responsibilities. And to put mass comms in place to make site wide lockdown easier to achieve. It has to happen across all trusts. We need collaboration from staff. It can be difficult because they already have so much to do. Now they have to fill in the information I'm asking for as well. Mass comms is difficult in the NHS. But we need to achieve that for Martyn's law.'

(Interviewee 1 – in-house security lead)

2.37 One interviewee highlighted the importance of developing procedures with emergency services:

'It's important to build a good relationship with emergency services – you contact them, don't wait for them to contact you – the local fire service, local police, and a team if you can get to know a team of that force because individuals come and go. Establish regular meetings. Plan how the communication works. It is like sprinkler alarms; you hope you never use them, but they are there if you need it. The biggest message is don't think it will never happen to us, you need to be prepared, you need to be ready.'

(Interviewee 8 – other security expert)

2.38 They also flagged the need for healthcare organisations to address **'insider'** threat:

> *'The risk of insider threat – there can be people that have those intentions and are planning it and will train up to get in and have bad intentions. How careful are hospitals and health settings checking credentials and their past?'*
>
> *(Interviewee 8 – other security expert)*

Section 3. Recruitment and retention of security personnel

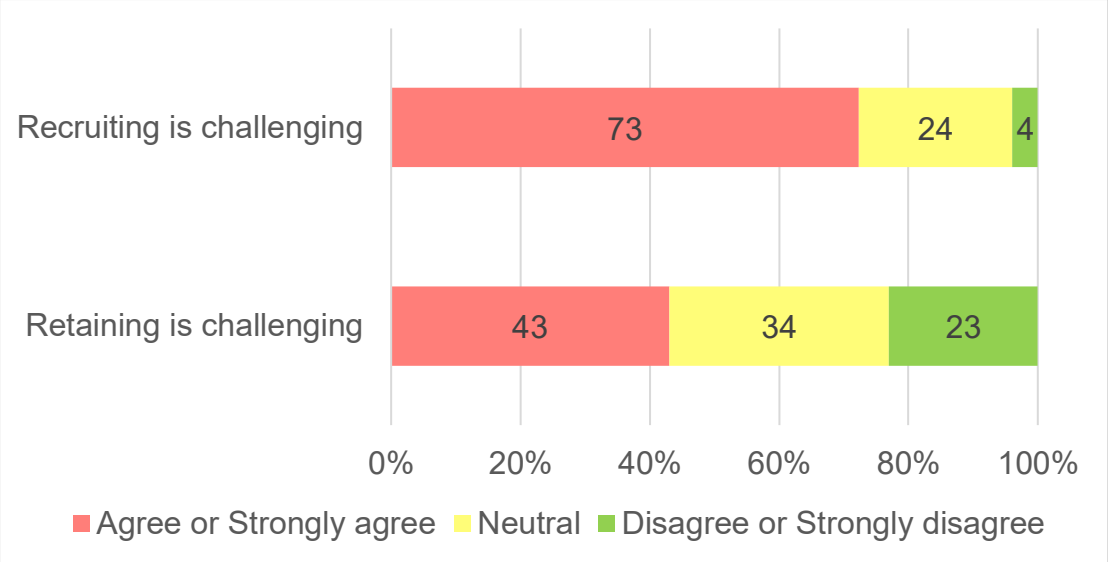
3.1 Given that, generally speaking, across the security sector, companies have found it challenging to recruit and retain security personnel (at the frontline level), the survey sought to gauge whether this was the case within healthcare specifically, and if so, the factors perceived to have the greatest impact, including the significance of the levels of violence and aggression occurring within healthcare settings. Indeed, it **does** seem to be the case, and **recruitment more so than retention**.

3.2 Close to three quarters of respondents (73%) agreed or strongly agreed that ***recruiting*** *suitable security staff for our organisation is challenging.* Notably, of this number 41% of respondents had **strongly** agreed (and 32% 'agreed'). Close to a quarter (24%) were neutral, and only 4% disagreed or strongly disagreed.

3.3 Meanwhile **retention** also appears to pose a challenge but to a **lesser** degree than recruitment; just over two fifths (43%) of respondents agreed or strongly agreed that *retaining security staff at our organisation is challenging*. A third (34%) were neutral and close to a quarter (23%) disagreed or strongly disagreed.

3.4 Figure 1 displays the result.

Figure 1: Agreement/disagreement that recruitment and retention of security personnel is challenging (n=109 to 110) %



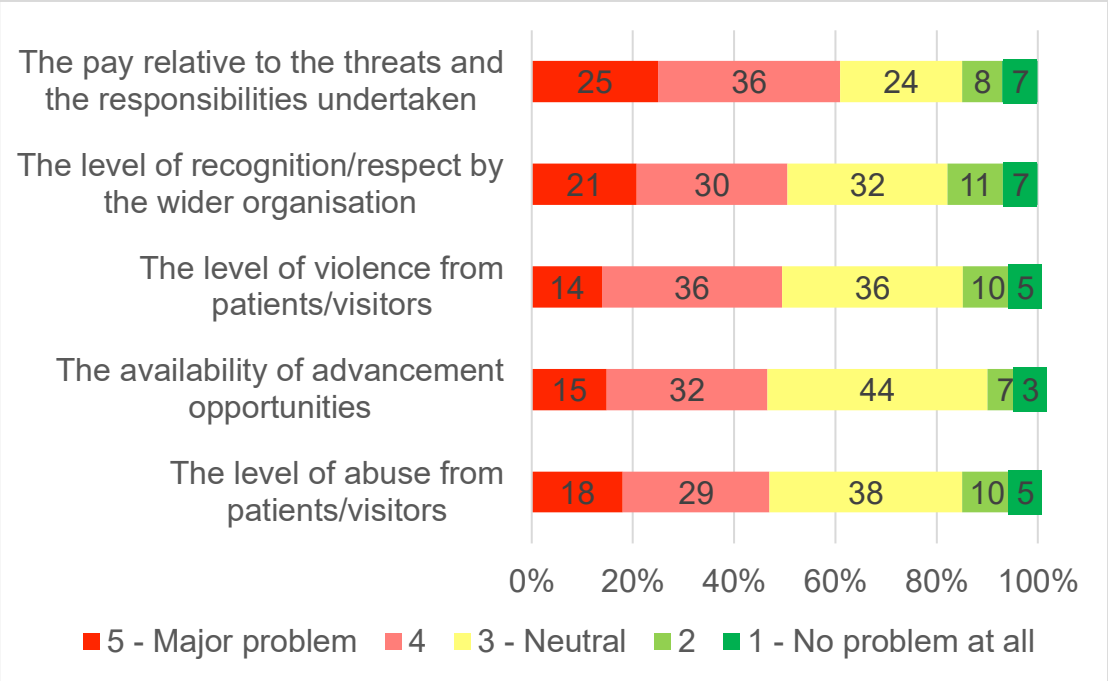
The factors impacting on recruitment and retention

3.5 Looking in more depth at the issues that may be problematic for recruitment and retention, in respect of the factors that may affect individuals wishing to work in a healthcare security role, *the **pay** relative*

to the threats and responsibilities undertaken edged ahead of other issues such as the level of **violence and abuse** and the lack of **recognition and advancement**.

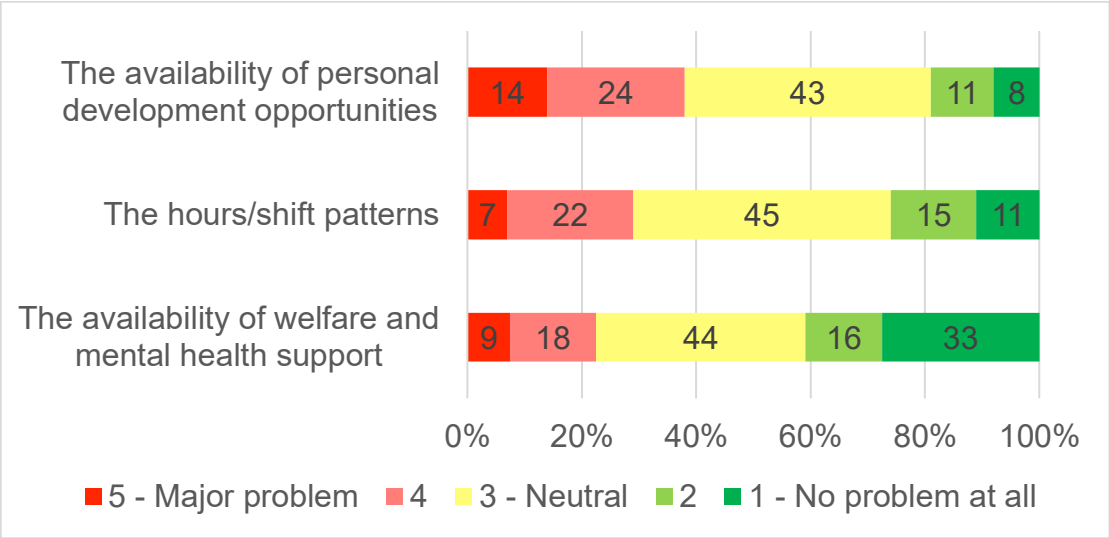
3.6 Specifically, three-fifths (61%) of respondents indicated that the **pay** was a problem, and around half flagged the level of **violence** (50%) and the level of **abuse** (47%) from patients/visitors, as well as *the level of **recognition/respect** by the wider organisation* (50%) and *the availability of **advancement** opportunities* (47%). Figure 2 illustrates these findings.

Figure 2: Factors with the most impact on recruitment and retention (n=106 to 107) %



3.7 Other issues that were covered but thought to be less problematic for recruitment and retention were the availability of personal development opportunities (38% indicated this is a problem), the hours/shift patterns (29%) and the availability of welfare and mental health support (27%). These findings are shown in Figure 3.

Figure 3: Factors with a lesser impact on recruitment and retention (n=105 to 107) %



3.8 A point not covered directly by the survey (which focused more on the attractiveness of the role) but raised by a number of respondents was that a key challenge for recruitment and retention was the generally **poor standard of applicants,** meaning that the challenge was not in attracting people, but in attracting the **right people for the right reasons**:

> *'Recruitment is fairly easy but getting the quality of staff is difficult as a low paid position. There's no standardisation – SIA don't have an NHS licence. There's no national register for us to check if they have a history. We can only go through the usual checks. People do slip through the net because they are able to … especially around Covid. There's no proper educational stream, no licencing stream – nothing for NHS – we just end up with someone who is happy to be repetitive, boring role, for low money.'*
>
> *(Interviewee 5 – in-house security lead)*

> *'We struggle to recruit staff with the right values, we still see too many applications from "doormen" security staff.'*
>
> *(Survey respondent)*

> *'With Job centre plus, if you are unemployed, if a security role matches with individuals out of work, they will say there is a job here for you and that individual has to apply, if they don't, their benefits will stop. That person doesn't want to do the job. They apply or their benefits will get stopped.'*
>
> *(Interviewee 10 – contract security management)*

> *'It is difficult. A good candidate for a security officer would have experience of security and of healthcare. But you are not going to get that for the pay offered. They may have done event security, and we hope we can train them up.*

Or they've done some healthcare work, and you think, let's hope they can get the security element.'

(Interviewee 1 – in-house security lead)

3.9 One interviewee found that they had a wealth of applicants but that many were from overseas and would need to be sponsored to come to the UK, but that the banding of security roles meant this was simply not possible:

'We are inundated with applications. For the last one we had 500 applicants. 90% are from overseas people without a visa and just asking for sponsorship or on a temporary visa. There is a massive amount from India because the NHS has an agreement to bring in staff like nurses. They bring their families with them, and they want to work for the NHS and want sponsorship. We've had some stand up and walk out when we say we can't sponsor them even though we've said it throughout the application process. You have to be band 6 or 7, I think, to qualify. There's nothing we can do.'

(Interviewee 1 – in-house security lead)

3.10 They also found increasingly that applications were misleading and appeared promising due to the use of AI, but in some instances were completely unsuitable. They noted the pressure they were under to take on people from overseas to avoid exhibiting discrimination in recruitment practices, but highlighted that this was not an issue of race but that effective communication skills are so fundamental to the role that it would be potentially dangerous (to patients and staff) to employ people that can't understand English (to properly understand policies and procedures) or communicate with others in English. The interviewee explained why they felt communication skills were so significant to healthcare security:

'98% of the applications are chat GPT. Most are the same. They sound perfect on paper, but they then turn up and can hardly speak English. We've had times when we've had to re-advertise because everyone we saw, it was all lies. In security in general, communication is so important. But in healthcare security it's even more important. All we have is our voice and de-escalation. If we don't have our voice, all we have is our hands and restraint and that should be a last resort. We need to communicate our way out of situations. With a Dementia patient, you have someone being racist because they are in their 90s and they are terrified because they have got someone that looks like the police, can't speak English and is holding them. For safety reasons we need people that are able to communicate. We are pushed increasingly to have to take these people because it's politically correct. It is important to have a diverse workforce, but they need to be able to do

the fundamentals or people get hurt. This is our laws. Safeguarding. It's difficult, it's hard to manage.'

(Interviewee 1 – in-house security lead)

3.11 One interviewee noted that a change in SIA criteria for applying for a licence, while needed to ensure appropriate people are given a licence, may further **restrict the pool of candidates**:

> *'Another difficulty is the SIA is changing the criteria of who can apply for a licence. They have expanded the criminal convictions that can't apply. I don't think people with criminal convictions should apply, but it is going to restrict the pool and companies may lose officers that no longer meet those rules. They are enhancing the vetting as well. The pool of people are from other countries that can't prove vetting. [From some countries] they can't get a records check so that will rule them out.'*
>
> *(Interviewee 3 – contractor security management)*

3.12 Another noted that rules on the length of time spent out of the country could also limit the pool of candidates:

> *'It is limiting our pool. If they have been out of country for more than 4 weeks, they will need a criminality check for the last 10 years.'*
>
> *(Interviewee 2 – contractor security management)*

3.13 Another interviewee commented in more depth about how the nature of the role may not be attractive to a wider pool of people:

> *'If someone is going to be a security practitioner – choosing to work in certain environments. With healthcare and with some other sectors like universities the work is 24 hours in nature. The shifts are different to retail where you are not working nights. That makes it less attractive. And female security officers – you have issues there in getting diversity – particularly gender diversity. The lack of flexibility within most rotas probably doesn't help attract that wider group.'*
>
> *(Interviewee 9 – in-house security lead)*

3.14 One interviewee noted that some recruitment practices were dated and that in some instances further thought was needed to attract the right people to healthcare security:

> *'Heads of security for trusts – want to attract and retain a better quality of candidate – it is a problem. Job adverts – wording is a problem. The security sector is very dated, it is filled with a lot of people who have been there a long time so still working off job advert or personal spec of their idea of what a person should be and just being regurgitated. In my experience they don't need a security*

background – you can teach that – they can't teach you to be a great person.
If a job ad dates back to 1975 – you need an armed force background – SIA licence. Therefore, a lot of women and people don't even look at adverts in security. With the word security – very masculine. There are some people now getting in, that wouldn't have, say, even 18 months ago, and are brilliant – but people who are charged with retention and recruitment are affecting this – conscious and unconsciously.'

(Interviewee 6 – other security expert)

3.15 Some noted that a difficulty has been created for the recruitment process (and ensuring candidates are suitable) by the removal of **probationary periods**. One interviewee provided the context that probationary periods (at least for security and possibly other roles) were not currently permitted within the NHS meaning that it was difficult to remove unsuitable staff:

'One struggle is the probationary period. It may be an NHS problem. We're not allowed to do a probation period. The NHS is desperate for people. But for security, a lot of the time, they can't cope with it and then we are stuck with them. We can't get rid of them. Stuck with someone that goes off sick. Paying them. We can't get them to work, or they are very incompetent. We need to have that probation period.'

(Interviewee 1 – in-house security lead)

'Probationary period for new staff as whilst retention is an issue, so is the removal of individuals who are causing damage to the department from within.'

(Survey respondent)

'Probation periods are essential.'

(Survey respondent)

'We no longer have a probation period, this makes it hard once established that recruit is not suitable for the role, undertake poor performance etc. My Trust need to re-introduce at least x6 months' probation period.'

(Survey respondent)

Addressing the recruitment and retention challenges

3.16 In open survey comments and interviews, there were two main themes that emerged as essential to addressing the challenges – addressing the **pay** and creating a **specialism** that provides a **career**. These are considered in more detail below.

The package, particularly pay

3.17 The main solution that respondents could see was to make the role more attractive to the right calibre of individual by improving the package offered to candidates in terms of welfare, hours and support, but particularly through improved pay. Indeed, there was a common view that current pay levels do not adequately **reflect** the nature of the work in healthcare security:

> *'Better pay for what is expected of them in an NHS environment. Living wage is not enough when they can get the same pay on a gatehouse rather than work within the challenges they have to deal with on a daily basis.'*
>
> *(Survey respondent)*

> *'Rewards for increasing competency and paying at least the living wage rather than minimum wage, increase out of hours pay rates.'*
>
> *(Survey respondent)*

> *'Better rates of pay, opportunities for promotion, better work life balance. H&S support culture, including mental health teams within the organisation.'*
>
> *(Survey respondent)*

> *'Increase pay, improve shift schedules, improve visibility of management in order to support staff initially.'*
>
> *(Survey respondent)*

> *'Security is sub-contracted out. No issue in retention however officers on living wage which for the hours and amount of work they do is way below what they should be on. However, when the contract goes to tender the Trust always want the cheapest as they have other priorities.'*
>
> *(Survey respondent)*

> *'It's pitched as pretty much minimum wage. There are very few professions on minimum wage. If it's about professionalisation it needs to be rewarded for the judgement calls they need to make.'*
>
> *(Interviewee 7 – other security expert)*

> *'[Officers working at a specific banking group] barely see conflict, they are on at least £5 more an hour. It's disproportionate. But it's what clients are willing to pay – that is what will attract better candidates.'*
>
> *(Interviewee 2 – contractor security management)*

> *'If you go out to the market – if you ask someone to come on minimum wage and don't have to have SIA licence, you will have an interested party that you don't want. You might get a good person out of that bad bunch, and they will realise it's not for them because the money is not good, and what you are expected to do is not worth the money. They would rather go and stand in [large supermarket chain]. If we've got pay which is good, terms and*

conditions, baseline of SIA licencing – a level of training – then we are starting on the right foot on expectations of individual. We will get a better calibre of staff. You are going to get someone that is attracted because they want to do it.'

(Interviewee 10 – contract security management)

'Originally I did corporate banks in London. You don't really get violence and aggression. It was stopping people getting in and a hundred and one things, but violence and aggression is an anomaly there. In A&E it's not the same as the NTE but it is moving more that way, so there is that difference in those expectations.'

(Interviewee 9 – in-house security lead)

3.18 One interviewee noted that this was an issue across the security sector (not just healthcare), and that it was crucial to treat security well given that they are the ones who have such a significant role in preventing and responding to emergencies:

'The best way to make it more reliable, is to pay them better, give them contracts rather than ad hoc. If they employ the same member of staff, rather than agency that don't know your building, your exits, that only have 15 mins briefing. Good security is when people know the building, have a sense of belonging, are given a uniform, and good working conditions, not do double shifts. They shouldn't work at the same entrance all the time, they should rotate so they are always attuned to danger. Good security is when security is not seen as an add on, it's seen as a key role in any organisation because those people can turn into first responders.'

(Interviewee 8 – other security expert)

3.19 One survey respondent specifically noted that the current pay banding was **illogical**, given that higher banded healthcare staff would be seeking to escalate an incident to lower banded security staff:

'The way security set up in NHS organisations (speaking from experience working in 3 different NHS Trusts and visiting 7 other NHS Trusts) are that security are taken to be on band 2/3 with security supervisors being on band 3/4, but yet security are seeing as nursing staff escalating to security while being on band 4/5/6 and band 7. To which it doesn't support escalation processes, as it should be lower band escalating to higher band. It is the same as if RN would escalate to HCA in medical field? In my opinion security should be promoted as a higher responsibility holding roles, those equal to a step lower from police personnel.'

(Survey respondent)

3.20 Indeed, a number of respondents made specific suggestions around what they thought would be a **more appropriate NHS 'banding'** for pay for security roles with most suggesting band 3 or 4 would be more appropriate than the current band 2 that is commonplace:

> *'The security staff in my organisation are band 2, which doesn't reflect the responsibility, or the pressures of the role and I would like to see a national move for improved pay scales.'*
>
> *(Survey respondent)*

> *'Nationally, would always advocate in-house security in acute hospitals and feel pay band should be Band 4 given level of duties, responsibilities and risks they have to deal with it.'*
>
> *(Survey respondent)*

> *'Managers are actively blocking the job description from getting banded. We are doing far more and have more responsibilities than what we are receiving payment for.'*
>
> *(Survey respondent)*

> *'On an average of 245 V&A incidents per month the current Banding is 3 which should go under review to be at least a Band 4.'*
>
> *(Survey respondent)*

> *'UK banding within NHS set for Security Officers. B2 is currently the recommendations and Trust stick to that as best they can. Given the ask of officers, this should be increased, and monies found.'*
>
> *(Survey respondent)*

> *'… a level playing field in terms of NHS salary. There is banding in the NHS – most security fall under band 2. There should be a national agreement for them to be band 3 to give the motivation to do a professional role. At band 3, the pay and you might get some overtime in there. The chances of them staying is for me far better than the other aspect when you have someone told to go there.*
>
> *(Interviewee 10 – contract security management)*

3.21 One survey respondent noted that the need for a re-banding had been recognised and was being applied within the Trust they work for:

> *'The trust has recognised that the work conducted by the security officers across all Hospital sites is above the pay bands they are currently being paid, this is being addressed and the Officers will be going up a pay band. Band 3 will now go to a 4 a Band 4 to a Band 5 and a Band 5 to a Band 6.'*
>
> *(Survey respondent)*

3.22 Some respondents felt that bringing security **in-house** would be a way of improving the quality of officers and the pay:

'Move all security into in house positions to ensure correct recruitment, vetting and DBS standards are in play. Correct levels of pay and benefits to reflect the roles undertaken, and access to health and wellbeing services.'

(Survey respondent)

'National steer on JDs including all officers being employed directly to the NHS trusts employing them we need to move away from agency's being employed directly due to variations in training the NHS needs to take control of these issues working in partnership with each other.'

(Survey respondent)

3.23 And two interviewees flagged a point touched upon above (in respect of the need for a consistent approach nationally to buying security), that the **procurement process** often worked to keep pay low which prevents any progress being made in the standard of individuals employed:

'To some extent, the security companies and the procurement managers of the NHS acutes are complicit in this race to the bottom. Tenders for supply predominantly judged on price not quality so you do not get the team wanting to work for you. You only have to look at where salaries are higher and the higher quality of officers to appreciate how valuable the quality is. It never ceases to amaze me.'

(Interviewee 9 – in-house security lead)

'I think we need [to set a minimum] that you cannot pay less than X. That has to be law – it has professionalised security in other countries. We operate globally so I've seen that in other countries there are laws that protect security from a race to the bottom. There was one [contract] where we didn't win a bid because our price was £1 million higher than our rival. We were doing it input based. How can a security company come in £1 million less [for the same thing]?'

(Interviewee 3 – contractor security management)

3.24 One interviewee noted the reality that achieving an increase in pay could be challenging and that further consideration could be given to the **overall package** and whether there were perks that other NHS staff got that security may not be getting. They also highlighted the value of the work and whether more could be done to promote the positives:

'I think the issue is about quality and experience for these more challenging settings. I think it comes down to the package offered by the employer. If they can't offer money, do they get the NHS pension – do they get the staff discount in the canteen? The hours and shifts I think and the intensity of the job – do you want to be in a mental health setting where it is relentless? Do you want to do the A&E night shift? How can employers make it an attractive

package? Something that is more of a positive. In retail officers say they want to do it to help others. I would think in the NHS it is doubly so. Protecting something in critical healthcare. There has got to be something to promote as a positive around this. Change the pay rates or pipeline progression, stay with us for 3 years and this is the progression. Ways to incentivise people. It's how to pitch all of it.'

(Interviewee 7 – other security expert)

3.25 Another interviewee made a similar point about the work being rewarding, and the need to make people feel like they are **part of something**:

'If you invest in the individual and make them feel welcome, give them the right policies and processes. Patient care is rewarding. Make them feel part of a team. NHS pension is good.'

(Interviewee 10 – contract security management)

Creating a specialism and a 'career'

3.26 There was also a view that a key part of addressing recruitment and retention challenges was to develop healthcare security as a 'specialist' area that provides a career and therefore would become more attractive:

'In terms of recruitment – professionalise. It needs to be a professional career. The solution is specialism. Supervisor or manager has some kind of clinical training. Specialist officers. Part of the decision making. Sit on restraint meetings. Have a voice, be part of the table. Work seamlessly. Sit in departments, not patrols – go in and work as part of team. Similar uniform but identified, badge on display – spot problems – behavioural detection comes in.'

(Interviewee 2 – contract security management)

I think healthcare security should be a separate career branch from all other security types (corporate etc.)

(Survey respondent)

3.27 One interviewee noted the need for a united approach on creating a healthcare security career, overcoming competition between contractors to find better ways of providing security in the healthcare context:

'We need to make it a career of choice. It's down to the businesses. More attractive, benefits, career progression. Everyone who operates in healthcare can benefit. We will go to [a healthcare security conference] and will speak to half a dozen people – there won't be any sharing – it's competition. We are competitors. We need a think tank of

healthcare security providers to come up with solutions – with no motive. To provide a better service.'

(Interviewee 2 – contractor security management)

3.28 More generally suggestions including creating development pathways, and improved qualifications and training:

'Actual development pathway for officers.'

(Survey respondent)

'Identify progression pathways, remove current freeze on appointing to non-clinical roles.'

(Survey respondent)

'Improved qualifications and Training.'

(Survey respondent)

'The process of induction, training and support would enable the new officer to be prepared for situations. Training is crucial in the litigious world we live in and enable the officer to determine what to do and when. Experience with like-minded supervisory support would prepare officers to deal with situations.'

(Survey respondent)

3.29 The issue of developing specialist knowledge is explored in further detail in the subsequent section of this report devoted to 'Training' (see Section 5).

Section 4. Operational issues

4.1 The security sector generally is known to experience challenges that impact on the quality and efficiency of security operations, for example: obtaining sufficient resources and staffing to meet the demands; obtaining a police response to relevant incidents/crimes (due to the police's own resourcing challenges); varying expectations from organisation managers (and staff) of what their role is, how they should conduct it and crucially on how and when to intervene, including with the use of force/restraint.

4.2 The nature of healthcare environments creates potential for these issues to be exacerbated – many settings are public sector and the financial burdens on the NHS are well documented; the police are adjusting their response to health-related incidents (under 'Right Care, Right Person') which has the potential to increase the pressure on other healthcare staff (including security); and the diverse range of departments that can exist within healthcare settings creates added complexities for security.

4.3 The survey therefore explored respondents' views on a number of these issues, to explore their significance and identify any aspects that may be most challenging.

The key operational challenges

4.4 Of the issues explored, those relating to **collaborating** with other departments and stakeholders appeared to be a focal point; two-thirds or more of respondents agreed or strongly agreed with the following:

- *security personnel face **inconsistent expectations** across departments or locations within the organisation* (69%)
- *there is a **lack of shared understanding** (between security and clinical staff) regarding the procedural limitations, that govern the use of restraint/control techniques by security personnel* (63%)
- *the **police do not give sufficient priority** to incidents (when a police response is required)* (60%)

4.5 These were followed by issues relating to **resourcing of/demands on security staff**; close to half of respondents agreed or strongly agreed that:

- *we do **not have enough** security staff* (50% agreed or strongly agreed)
- *the amount of time spent responding to incidents means there is **not enough time** for preventative security tasks (e.g. patrols, checks etc.)* (46% agreed or strongly agreed)

4.6 Less than half of respondents (46%) indicated that security staff receive appropriate training to deal with violence or high-risk situations; a fifth

(22%) disagreed (and a third, 32%, were neutral). This is notable given the prevalence of violence and aggressive (explored further below – see para 4.9 onwards).

4.7 Responses were more **mixed** in respect of resourcing of security technology and in respect of mental health and wellbeing support, which may reflect different approaches being taken at different healthcare organisations:

- 43% **disagreed** but 37% **agreed** - *we have sufficient financial resources to ensure appropriate physical security measures are adopted (e.g. access control, CCTV, etc.)*
- 43% **agreed** but 38% **disagreed** - *there is adequate mental health and wellbeing support available for security personnel (e.g. if they are involved in a traumatic incident at work)*

4.8 Table 2 shows the full breakdown of responses ordered by the level of concern shown by respondents.

Table 2: Operational issues ordered by level of concern (n=117 to 122) %

Issue	Agree / Strongly agree	Neutral	Disagree / Strongly Disagree
Security personnel face inconsistent expectations across departments or locations within the organisation	69%	22%	9%
There is a lack of shared understanding (between security and clinical staff) regarding the procedural limitations, that govern the use of restraint/control techniques by security personnel	63%	23%	14%
The police do not give sufficient priority to incidents (when a police response is required)	60%	21%	20%
We do not have enough security staff	50%	22%	27%
The amount of time spent responding to incidents means there is not enough time for preventative security tasks (e.g. patrols, checks etc.)	46%	38%	16%
Security staff receive appropriate training to deal with violence or high-risk situations	46%	32%	22%
We have sufficient financial resources to ensure appropriate physical security measures are adopted (e.g. access control, CCTV, etc.)	37%	20%	43%
There is adequate mental health and wellbeing support available for security personnel (e.g. if they are involved in a traumatic incident at work)	43%	19%	38%

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Occurrence of security-related incidents

4.9 Violence and aggression is generally recognised as a key issue both in healthcare settings and across the security sector. Healthcare consistently features among the sectors reporting higher rates of violence and aggression[15] and is thought to be increasing in prevalence. Further it carries potentially severe psychological and physical impacts for the individual(s) involved and wide-ranging impacts for the organisation. Yet there is currently no national mechanism for monitoring and analysing violence and aggression and other security related incidents within healthcare.

4.10 In order to gauge the extent of violence and aggression and understand the types of incidents that may be harder to prevent and/or that may place more demands on the time of security personnel within healthcare, respondents were asked about the frequency of a number of types of security-related incidents.

4.11 'Violence, aggression or abuse', and anti-social behaviour[16] were the incident types reported to be occurring **most frequently** with 70% or more of respondents indicating these occur daily or weekly.

4.12 *Violence, aggression or abuse by **patients** against staff* was the **standout** issue, with 81% of respondents indicating this is a **daily** occurrence.

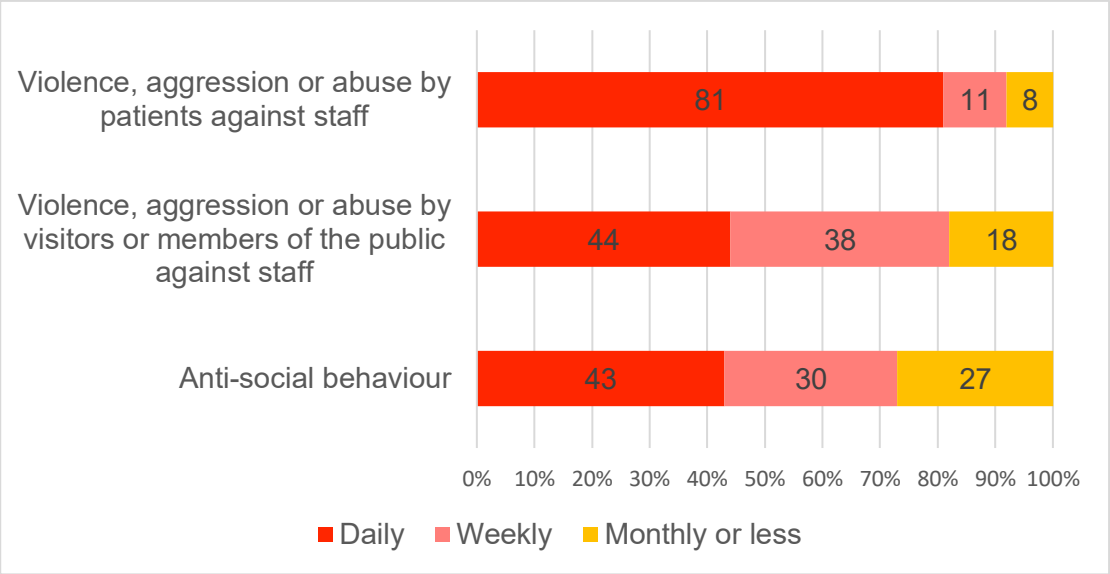
4.13 Meanwhile *violence, aggression or abuse by **visitors or members of the public** against staff* and *anti-social behaviour* were more evenly split between occurring **daily** (44%) and **weekly** (38%).

4.14 These findings are displayed in Figure 4.

[15] See for example: Gash, V, Blom, N. 'Workplace violence and fear of violence: an assessment of prevalence across industrial sectors and its mental health effects'. *Scandinavian Journal of Work, Environment & Health*.

[16] We described this in the survey as including behaviour such as: vandalism, damage to property, gang-related activity, intoxicated or drug-affected individuals.

Figure 4: Incident types considered to be most prevalent (n=114 to 117) %



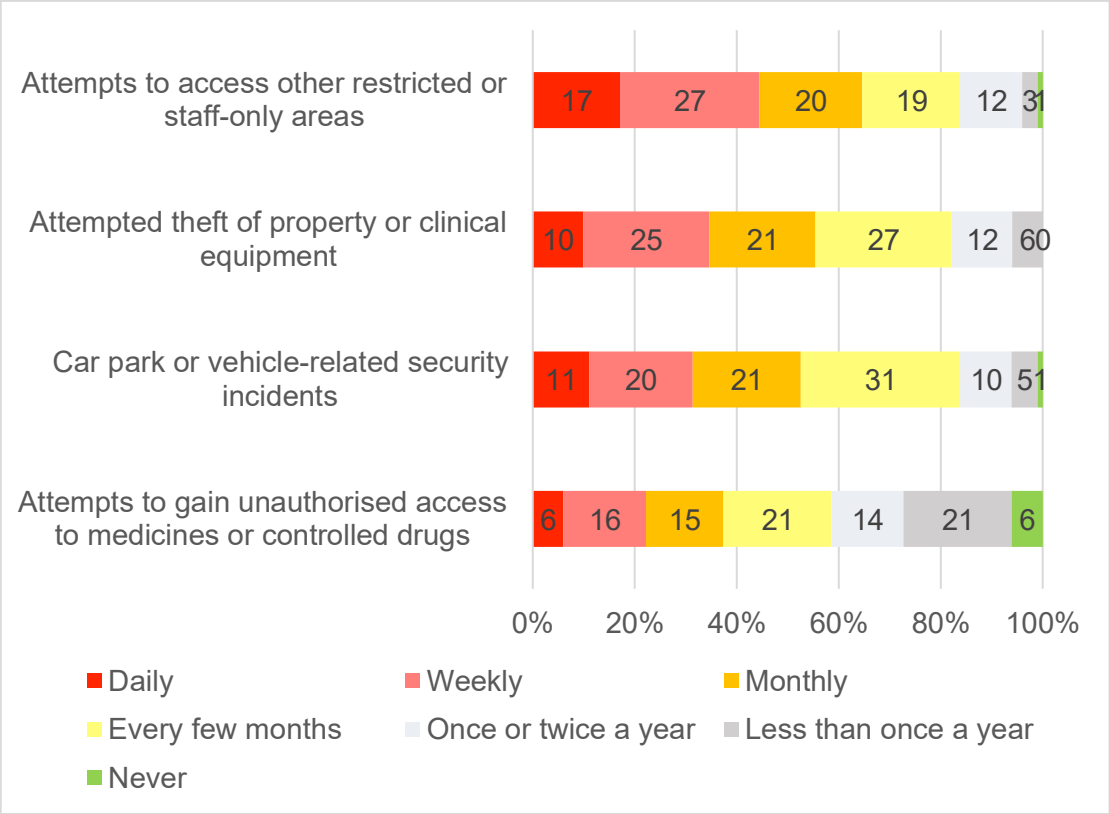
4.15 The other incident types explored were generally more **dispersed** in terms of respondents' views on their frequency. It should be noted that in the survey, where we referred to 'attempts', we described these as including both successful and unsuccessful acts.

4.16 *Attempts to gain unauthorised access to **medicines or controlled drugs*** were considered the **least** prevalent, presumably aided by being able to apply stricter procedures and controls in those areas (22% of respondents indicated these occur daily or weekly).[17] Meanwhile *attempts to access **other** restricted or staff-only areas* (i.e. other than where medicines/drugs are stored) posed **more** of a challenge (44% of respondents indicated these occur daily or weekly).

4.17 Figure 5 displays the results for the other incident types (i.e. other than 'violence, aggression and abuse' and 'ASB' – which were shown above in Figure 4).

[17] It is worth noting that during the COVID-19 pandemic, NHS drugs were targeted by Organised Crime Groups due to the difficulties posed for using their normal supply routes, because of the restrictions on movement, highlighting the potential for unforeseen spikes in this type of incident.

Figure 5: Other incident types by prevalence (n=109 to 114) %



Addressing the operational challenges

4.18 Expanding on the issues above, interviewees and survey respondents highlighted a number of ways in which operational challenges needed to be addressed. These are considered in turn:

- Clarifying the role of security
- Improving collaboration with the police
- Properly resourcing security

Clarifying the role of security

4.19 Both survey respondents and interviewees highlighted the need to improve collaboration with other departments, particularly clinical. At the heart of this issue was the need to increase understanding of the **role of security officers** within healthcare organisations and more specifically about what security officers can and can**not** do:

> *'From my experience, right back to late 90s early 2000s, that lack of understanding of what security are there to do. Lack of understanding of security staff's role and capabilities.'*
>
> *(Interviewee 10 – contract security management)*

> *'I think there's a general misconception that security staff (especially external 3rd party ones) have extra powers. We*

know that they don't, but staff or public don't understand this. They do have some powers under the Mental Health Act but in a general way, they don't have any more powers than anyone else. Just because you wear a uniform with a high viz vest – lay and non-security people expect more from them than they can actually deliver.'

(Interviewee 6 – other security expert)

'Enhanced understanding between clinical and security what the latter can actually do.'

(Survey respondent)

'Working more closely with clinical staff. Handovers, cross understanding of workloads and expectations.'

(Survey respondent)

'A stronger approach to training services i.e. links between clinical and security.'

(Survey respondent)

'[Security] can be seen as someone in authority, wearing a uniform, representing the hospital. People look to them and have higher expectations.'

(Interviewee 7 – other security expert)

4.20 It was highlighted that security should **not** be 'leading' the response in scenarios where there are clinical implications, and that **security should sit under clinical leadership** when requested to assist in restraining/managing patients. This was seen as a key **misunderstanding** of security's role, capabilities and powers:

'The NHS is supposed to have policies – their policies say that the use of force should be clinically led. But security is left alone and called upon to restrain people – it can be for violence, but also things like having medication administered. The clinical staff have the same powers of security, but they back off.'

(Interviewee 3 – contract security management)

'Non-deliberate V&A (medically related, Dementia, mental health) does not sit with security. We have no influence in how these incidents are handled.'

(Survey respondent)

'Security services to sit under clinical leadership i.e. chief nurse for greater integration. Majority of victims are nurses.'

(Survey respondent)

'You can have an acute setting, where people are being triaged and assessed, that can fluctuate between acute illnesses and mental health. The NHS staff, nurses and doctors will be acute rather than mental health professionals. It becomes difficult when security is asked to control and assist in an incident. It can be out of their remit. Clinical would not necessarily understand that may

be the case. It's a loophole in the systems. We know this happens.'

(Interviewee 10 – contract security management)

'Where it becomes unclear is the clinical areas. If a member of NHS staff requests restraint, that needs to be clinically led and documented within the clinical notes. Security staff then become part of the team, rather than leading it. They take the head, do the observations, medical welfare, we will just restrict arms and legs. It's important that everyone working in that circle knows what the roles and responsibilities are.'

(Interviewee 10 – contract security management)

'It should be clinically led, but the Trust need to understand the culture and the role of security.'

(Interviewee 2 – contract security management)

'The whole issue of restraint, both by security staff and clinical staff, is still a major weakness. My trust is currently reviewing restraint policy. Clinical staff need to take responsibility and have full understanding of supervising security staff when a restraint is likely to be needed or is in progress - it's a patient safety issue.'

(Survey respondent)

4.21 One interviewee highlighted that this situation also caused **confusion among security staff**, and could lead to **inconsistent responses** within an organisation:

'We get [security] people that go above and beyond. When others stick to the correct process that causes problems – they did it, why won't you. It's very challenging. The key thing is that security and clinical know each other and work together to understand the barriers.'

(Interviewee 10 – contract security management)

'The nursing staff don't know what to do if someone becomes violent. There is a lack of understanding of what security are there for. Some don't know what their remit is. If you took 10 sites across the UK and asked them the same questions, you'd get 10 different answers. What can you tell me about your role if someone with Mental Health needs came to A&E? What understanding and training do you have? The answers to that would be totally different. It's all about education.'

(Interviewee 10 – contract security management)

4.22 This issue of security's remit was a significant one, with many respondents highlighting the **consequences of the boundaries being stretched beyond what was appropriate**. In some instances, the main problem with this was that it took security away from their primary (and important) purpose:

'We see other things from key account portfolio – more demand on additional duties – talking about the role of a porter [i.e. security officers being asked to do 'portering' tasks] – can they move a bed, move patients, pick up the litter from the car park.'

(Interviewee 2 – contract security management)

'It's about boundaries. For example, staff can take advantage of security – "wheel Mrs so-and-so to x-ray", but it's not safe for the patient or [security] staff. We need clear boundaries, and we just don't have them. They (security) do get bored, and I sometimes hear from staff "security has been doing this and that this week" and I see them on reception taking deliveries. But they're then not doing the job they should.'

(Interviewee 5 – in-house security lead)

Uniform security officers should engage only with security duties and restrict taskings that include non-deliberate violence and aggression, car parking and escorts.'

(Survey respondent)

4.23 In other instances, however it was noted that security staff can be directly asked to assist with activities that require clinical or other specialist accreditation/training/knowledge that security do not have. This could create **risks** to the patient and to the individual(s) and **breach guidance/legislation** opening up the individual(s) to consequences such as disciplinary action, dismissal and legal action:

'Security officers are generally used to fill a clinical staffing gap for managing clinically related challenging behaviour and invariably are required to support for patients both minors and adults with LD and complex needs. This isn't appropriate and outside of the security officer's remit and requires a clinical response of appropriately trained staff.'

(Survey respondent)

'We are finding our security officers are left alone to deal with things that should not be done by us. CQC – it is a bit of an ongoing project around patient minding. Security shouldn't be leading on that – it is directly against CQC guidance – which says it should always be clinically led. We're engaging with CQC to find out if we need accreditation, because we get left on our own because of NHS resources. The contract says we will be left alone. Directly against the CQC guidance.'

(Interviewee 3 – contract security management)

'Also, contractually we can't do everything unless it's in the contract. It's incredible what they put pressure on us to do even though it's beyond the contract. There was one where we were asked to transport a violent patient in a taxi. We said we couldn't, and they said it's in your best interest to do so because your contract is coming up to its extension

period. We pushed back on that, but I think they ended up doing it anyway. The pressure that is put on security. There is so much scope creep.'

(Interviewee 3 – contract security management)

'It leads to disciplinary, tribunal, legal issues. If you go hands on and get it wrong. It happens in our organisation, we see it, it is a problem.'

(Interviewee 3 – contract security management)

'In healthcare there is a lack of understanding of the role. Short notice of demands. Sometimes for a bed watch – they want someone there in 40 minutes – and say just get anyone – but if you just get anyone, that's when you get sued, and someone loses their livelihood.'

(Interviewee 2 – contract security management)

'My Trust has enough security staff on duty for day-to-day activities such as patrolling, incident response and control room operations but struggle with constant demands for additional dedicated security staff to bedwatch "high risk" or vulnerable patients; we have to use agency staff for this which is extremely problematic from a quality perspective.'

(Survey respondent)

4.24 One interviewee noted a related danger, of being involved in some clinical matters – that security could be led to believe they are acting under the **correct authority**; however it has **not been properly executed**, and another noted more generally the importance of ensuring they had evidence that authority had been given:

'And mental health law. Someone says stop them leaving they are under a section, and you do and then later you find out the paperwork is missing – they hadn't actually done the paperwork to put them under section so you've acted without the proper authority.'

(Interviewee 3 – contract security management)

'There was an incident where security staff were requested by a doctor, quite an assertive request. You need to do this. But that's not acceptable - the security staff need to ask under what powers and get that documented. I implemented body cameras. Some doctors would refuse to give a signature to give the powers to detain someone for their own safety. But it's got to be done properly or security are not protected. Activate the body camera – it's common now – so when the doctor makes the request – absolutely we will try and keep them secure – we will use reasonable and practical force if you are ok with that. Then we've got that on record. You need to safeguard yourself, then in the report you can justify that you used proportionate and necessary means to do that.'

(Interviewee 10 – contract security management)

4.25 Indeed, one interviewee noted legal action was not unusual:

'We are getting slammed with legal cases, disciplinary – security has done something at their [clinical] behest – and gets counter sued. The patient sues the hospital and the hospital sues us.'

(Interviewee 3 – contract security management)

4.26 To address this issue, many respondents highlighted the need for cohesion on **violence and aggression** and more specifically for a **joint approach** to be agreed and **joint training** among clinical staff, security staff and others where applicable, to ensure a clear understanding of the agreed approach:

'We definitely need a standard here. We need joint training here. It sounds obvious but they work in silos, and that is a problem. Security is seen as a necessary evil. There is not the liaison there so clearly needs to be.'

(Interviewee 4 – in-house security lead)

'More cohesion with the clinical teams on Violence and Aggression expectations and outcomes.'

(Survey respondent)

'[In respect of an increase in violence and aggression] The trust has seen the demand for security to be present in many of these hot spot areas and have listened to clinical staff regarding staff and patient safety, The trust has allowed the security service to carry on its recruitment of security officers and has also allowed for extra systems security to be put in place to help mitigate risk. There is never going to be a perfect answer but good clear collaborative work between security and clinical staff have helped better understand each other's roles has helped build a good team ethic.'

(Survey respondent)

'There needs to be a joined-up approach to include Safeguarding so that decisions made to remove a patient does not fall back on security - which on occasions will require containment using restraint and then security being scrutinised for their actions.'

(Survey respondent)

'Organisations should be working as a joint approach to all security and VR workstreams.'

(Survey respondent)

'Have the likes of safeguarding and others to participate in meeting aggressive patients, family and others. Have a lived-in experience.'

(Survey respondent)

4.27 Some felt that clinical staff in particular needed more training themselves in restraint, to reduce/remove the need for input from security where the

issue is clinical, due to increasing volumes of non-deliberate violence and aggression among patients[18]:

> *'Better training for clinical staff to safely hold patients instead of the reliance of security personnel, who then are subject to scrutiny, opinions and ready to blame those who try their hardest to help people, whilst others have an opinion without action.'*
>
> *(Survey respondent)*

> *'Clinical staff training in restraint and a better understanding as to what security's role actually is. Increase in calls for security support however the majority are clinical issues not security issues. Cohort of clinical trained staff to deal with non-deliberate (dementia, mental health, learning difficulties) violence and aggression.'*
>
> *(Survey respondent)*

> *'Clinical staff should be trained in restraint on dementia/mental health patients rather than relying on a small team of security (who are not clinically trained and do not know the patient). Non-deliberate V&A is a clinical issue not a security issue.'*
>
> *(Survey respondent)*

> *'Our staff are trained with a clinical focus, they're not trained or observe the softer clues in violence and aggression, and so they match it and that leads to escalations. Therefore, it's about training.'*
>
> *(Interviewee 5 – in-house security lead)*

4.28 One interviewee noted an observation that differences in the abilities and conduct of clinical staff between the **day shift and the night shift** could cause problems and therefore needed to be resolved:

> *'Anecdotally, night shift nurses, the work may be less engaging, and they may be more 'on their telephones' which causes issues and they don't have the customer service skills that the older, more experienced staff have. That causes a disconnect between staff which can have a negative effect on security staff when they come to deal with issues. They need to be able to communicate well and sometimes nurses can aggravate the situation.'*
>
> *(Interviewee 6 – other security expert)*

4.29 Two noted **varying cultures** towards violence – and that in some organisations violence can be **normalised** and therefore isn't reported or tackled:

[18] In 2018 the Mental Health (Use of Force) Act, became law. This work is overseen by the British Institute of Learning Disability (BILD) and the Association of Certified Training (ACT). This act relates to the use of restrictive interventions which includes control, restraint, breakaway, segregation, seclusion and rapid tranquilisation. Accredited training is managed and delivered through the aforementioned organisations. Phase One related to Mental Health. Phase Two (due imminently) relates to Acute, Healthcare Security, Ambulance and Secure transport.

'Some of the culture with clinical staff is that they expect to be assaulted – and don't complain – doctors say [the patient] didn't mean to do it – so they are never getting accurate data about incidents. Sadly this has become the normal - that clinical staff get assaulted – the number and types of incidents are skewed – what is acceptable and not varies between people and places.'

(Interviewee 6 – other security expert)

'A thousand NHS organisations would have different ideas about security, different interpretations across different departments, facing different levels of risk. E.g. for mental health, risks are higher, therefore, staff won't escalate an issue as they are used to it, compared to say someone working in the community.'

(Interviewee 5 – in-house security lead)

4.30 One interviewee noted how work in their organisation had improved the relationship and resulted in better understanding of remit and respective responsibilities; they gave a specific example in respect of how bed watches are now managed:

'We've improved the relationship with clinical staff. We've enhanced the patient observation programme. Clinical staff will do patient observations level 1, 2, 3 and 4. When the risk is up, security will come in and do the bed watch. Dealing with patients alongside the clinical teams – there's a lot more understanding between security and clinical.'

(Interviewee 1 – in-house security lead)

Improving collaboration with the police

4.31 A number of survey and interview respondents reiterated the view that the **police are struggling with capacity** and consequently there is not enough support with incidents. There was a view that the Police do not always attend the types of incidents that have been identified (by the Police) as warranting a Police response.

4.32 Some believed that the presence of security staff at a healthcare organisation enables the police to **prioritise other matters**:

'In general NHS staff would say the police don't come in.'

(Interviewee 5 – in-house security lead)

'A busy A&E is the same time that police are dealing with a busy city centre – it's a resource issue.'

(Interviewee 9 – in-house security lead)

'From interaction with front facing teams they believe the police take too long to turn up and when it comes to those with mental health issues, they put their hands up and take two steps backwards. They also seem to have washed their hands of violence and aggression in Emergency

Departments. If they do attend it's not timely. Generally, the police have backed off a lot for incidents of violence in hospital – they know there will be some security people on duty.'

(Interviewee 6 – other security expert)

'The response assessments – if you ring from a domestic home – and say a challenging individual is threatening to kill me, the police would be there within minutes. From a hospital the police would assess and know an adequate security department is in place and would downgrade it. Just because we've got trained security staff. That's how they assess calls. That doesn't help.'

(Interviewee 10 – contract security management)

4.33 Two main issues were apparent – that healthcare staff (including security) are increasingly exposed to violence and in the position of having to find ways to deal with it, despite **not having sufficient powers or knowledge to deal with it effectively**; and that a **lack of action** (such as prosecutions) for violence against healthcare staff (including security) is one of the factors that **enables the issue to continue**, and therefore leaves staff at continued risk:

'It is very difficult. In healthcare security officers are not as highly trained as the police are [to deal with violence and aggression]. And the legislation doesn't back you up. Security has common law behind you. And they encounter legislation which police rarely encounter – mental health, deprivation of liberty, children. Security is lower paid; it can get difficult.'

(Interviewee 1 – in-house security lead)

'Although police response has been mentioned briefly, it is a major factor in staff morale that police do not support hospitals in their fight against assaults and verbal abuse against NHS staff….Emergency workers. There is a two-tier system in play. Those who assault police officers are dealt with. NHS staff are regularly informed there is to be no further action.'

(Survey respondent)

'Police responses are lacking, and staffing, morale and general well-being are affected through lack of support, and prosecutions.'

(Survey respondent)

' ….often [police] say they don't meet the threshold of say assault or inappropriate behaviour.'

(Interviewee 5 – in-house security lead)

'Incidents such as assaults on staff should be looked at more seriously and stronger message across to the public of the consequences of assaults – e.g. cases of convictions.'

(Survey respondent)

4.34 One interviewee (an in-house security lead) noted the challenge that the vast majority of assaults occurring (within their workplace) were **low harm** and that this was why they often do not result in police action. Meanwhile staff on the receiving end of such assaults understandably **feel unsupported** by the lack of action. The interviewee reiterated the importance of having procedures in place and ensuring these are understood and followed by staff.

4.35 A specific area of concern was with regards to the recent implementation of the **'Right Care Right Person'** initiative[19] further affecting the response from the police. Respondents noted that this would increase the presence of individuals suffering with **mental health issues**, being in the types of healthcare settings with (clinical and security) staff that are **not trained** to deal with them, but having to try to manage violent behaviour:

> *'It doesn't help the police and Mental Health issues. A number of years ago – you used to have a 'safe place'. Say an individual was located with suicidal tendencies, on a bridge and needs help. The Police would turn up, put the individual on 136 and take them to mental health. I'm led to believe a number of years back a person was taken to a safe place which was a custody suite and deaths occurred. That scenario, if it happened now, the police would take the individual to A&E and discharge them to a nurse or doctor. Is that the right place? No, because there might not be a Mental Health crisis team there. It then becomes a security issue. I've spoken to NHS colleagues about this. A safe place should include trained individuals to deal with those requirements. A&E has got the welfare and care and it's secure, but does it have trained people? If not, it can't be [the safe place]. That's just one example of a number of changes that impact.'*
>
> *(Interviewee 10 – contract security management)*

> *'As an Acute hospital we are receiving more and more MH patients whereby our Security and nursing staff are not trained to deal with. The Police have recently passed their sec 136 responsibilities over to a contracted service - sit and wait - and have stated that they are not trained to deal with MH patients - equally so - Acute hospital staff are not trained in dealing with these patients and to have a mix of MH patients in amongst Acute hospital triage patients is very high risk which has not been considered and is very dangerous.'*
>
> *(Survey respondent)*

[19] https://www.police.uk/advice/advice-and-information/concern-for-welfare/right-care-right-person/

'Recurring issues are obviously violence within ED especially challenges with MH patients and right care right person reoccurring theme. Lack of resources doesn't help.'

(Interviewee 6 – other security expert)

4.36 One survey respondent suggested a need to **review** the situation now that the initiative is underway, and to identify ways of improving the approach; similarly, an interviewee highlighted a need to **re-think the role of security officers** (and how they are contracted and trained) to fill the gap left:

'Right Care Right Person has and continues to present challenges for the NHS and police. A review nationwide to share lessons learnt and potential improvement plans based on trust and police experiences to-date.'

(Survey respondent)

'The pendulum swings. There is no doubt that healthcare has relied too much on police to solve its problems, in the past. I am in no doubt private security needs to be enhanced. In the last year we have implemented 'right care right person' which stipulates what police will [respond to, but] 'right care right person' falls down when mental health people commit violent offences and need to be arrested but are not. There is a gap here generally and it spills over into the NHS community. So rather than solving the problem, it has exacerbated it. Now we need to do more so that the police do not have to attend. Private security can do this, and they have not been contracted on the right basis and they have not been trained as required.'

(Interviewee 4 – in-house security lead)

4.37 Respondents generally suggested there is a need for greater collaboration with the police, and a number highlighted the importance of developing **good relationships**, maintaining **regular interaction**, **and reporting** all incidents to create an accurate picture of the scale of the problem:

'Create a collaboration between the two. Understanding and respect. We try our best to maintain a relationship. Have meetings. We have an officer that spends a few days a week. We work together. He does bits of training about reporting and expectations. We help him as well. We have two former detectives on our team that do the paperwork and hand it over, ready. It's really up to management and police to maintain a close relationship. It comes down to communicating with each other. Both are doing difficult jobs. Both are under-funded and under-valued. Security officers are nowhere near as well trained or paid as the police officers.'

(Interviewee 1 – in-house security lead)

'It's important to build a good relationship with emergency services – you contact them, don't wait for them to contact you – the local fire service, local police, and a team if you can get to know a team of that force because individuals come and go. Establish regular meetings. Plan how the communication works.'

(Interviewee 8 – other security expert)

'Collaboration with all emergency services thus ensuring in a time of crisis, healthcare licensed security staff can better support the police and other emergency services i.e. immediate first aid, crime scene management, emergency evacuation/invacuation etc.'

(Survey respondent)

'In [specific county] we have set up a working group with the police. We review all practices – body cams – staff – point out good and poor practices.'

(Interviewee 5 – in-house security lead)

'[Since changing our structure] we have a huge amount of reports going in. It looks like our incidents are going up, but they were always there. Now we are showing it. It's challenging the culture. We are putting these incidents on the map for the police – they don't like it, but they need to know it's the reality, we're not hiding it.'

(Interviewee 1 – in-house security lead)

4.38 Some interviewees noted the potential benefits of having a police officer **stationed** at hospitals:

'In an ideal world you would have a couple of officers stationed at hospitals.'

(Interviewee 1 – in-house security lead)

'The hospital in [one area] – when I worked for [police force area] – that hospital was and will always be a hotspot. And it's the same elsewhere, the hospital will be their top demand. I think it's a valid solution – to have a close working relationship – pay for a police officer to be based in the hospital. Someone that can triage anything. Security shouldn't be a backup unless you are going to pay them the same.'

(Interviewee 3 – contract security management)

4.39 One interviewee (an 'other' security expert) highlighted the potential merit of using the **Cardiff Model** for violence prevention[20] to gain a better understanding of the issue and put appropriate responses in place; and of having **volunteers** in Accident & Emergency departments to talk to

[20] https://www.cardiff.ac.uk/documents/2665796-the-cardiff-model-for-violence-prevention ; this is a 4 step model of: (1) data collection on violent incidents, (2) research on factors increasing and decreasing the risk; (3) designing, implementing and evaluating interventions (based on the first 2 steps); (4) scaling up and implementing interventions shown in step 3 to be effective and disseminating prevention information.

people in distress and identify ways of dealing with the causes of their distress, in order to prevent it from escalating into aggression.

4.40 Respondents also noted **other ways of coping** with a lack of police response, given the significant gap between what a warranted police officer and a security officer can do, such as enhancing the **training, powers and equipment** given to security staff:

> *'Lack of Police response exposes Healthcare Security to a Threat not faced by other security staff - the issue of Police not attending hospitals to deal with violence means this routinely defaults to Security Staff - therefore it is now time to consider healthcare security staff having enhanced training, authority and PPE / equipment to deal with the threat.'*
>
> *(Survey respondent)*

> *'[In some instances] the only difference is handcuffs. That may assist security staff with some challenges.'*
>
> *(Interviewee 10 – contract security management)*

> *'I am a great advocate of [police and private security developing the approach to working together], but RSAS and CSAS[21] are far short of what we need. We do need healthcare to step up to take on roles police need us to do. To do this, we need governance and a structure here, a set of standards, and an obligation to follow them. That will provide a focal point and then security expertise will be recognised. It isn't now.'*
>
> *(Interviewee 4 – in-house security lead)*

> *'I think it's better training for security officers. The length of training a security officer does. 6 days for a DS licence – that's the default licence most people have. Put that in comparison with cabin crew that get 6 weeks. Compare that with the British Army – around 58 weeks. The bar been set incredibly low in terms of the training given in this country.'*
>
> *(Interviewee 9 – in-house security lead)*

> *'I think security should be a step before escalating any issues to police, however at present security would not have same or similar powers close to police officers.'*
>
> *(Survey respondent)*

> *'Creation of a Healthcare Security Officer role in legislation with additional authority.'*
>
> *(Survey Respondent)*

4.41 However, some interviewees had **concerns** that additional powers or equipment that tried to mimic the police without the skills and ability needed, was **not a viable solution**, because it may be ineffective, or not

[21] RSAS – Railway Safety Accreditation Scheme; CSAS – Community Safety Accreditation Scheme

conducive to a clinical setting and potentially escalate rather than de-escalate:

> *'I'm against that – I don't think security need extra powers. We have a security and a police force – they shouldn't [do the same role]. Some [in the security industry] are pushing for a 'blue card' to get the powers of arrest and carry cuffs. That's a huge step back for the industry. We should invest in training, not handcuffs. Some are trying to get the narrative over the line. Some of the security officers out there. It would be anarchy. If they were suitable to have those powers, they would be police already. They are not police because they can't be. Extra powers are not the answer, training is the answer. A knowledge of conditions, understanding.'*
>
> *(Interviewee 2 – contract security management)*

> *'The idea that they put you in body armour and boots – I hate that arrogance that comes with that, that you are invincible. [we have] softened the uniform to chinos and subtle body armour. Because if you rock up – the aggressor is already heightened. Instead, let's bring them down – let's have a chat.'*
>
> *(Interviewee 2 – contract security management)*

> *'Pretending to look like police. Some [clients] want them to wear handcuffs, one wanted CS gas. We push back – we're going to lose the contract. But I'm fine with that because it's the right thing to do [to push back]. All that – as a former police officer, the last thing you want to do is pretend to be a police officer. The idea of doing all that, for minimum wage.'*
>
> *(Interviewee 3 – contract security management)*

4.42 One interviewee suggested that **extending** the specific offense of assaulting emergency workers **to include healthcare security** may be more appropriate:

> *'Is it not about powers – they can do a citizen's arrest. You can use force to defend yourself, the same as anyone. [Can the protections given to emergency workers] extend to security? That would help to give some cover to security officers.'*
>
> *(Interviewee 7 – other security expert)*

4.43 It is worth noting that there is currently an 'Integrated Policing and Private Security Initiative' in the UK (albeit this encompasses, but is not healthcare specific) which is exploring whether and how private security may take on some activities currently delivered by Police. This may hold

potential for addressing the issue of how to compensate when the police cannot respond.[22]

Properly resourcing security

4.44 In respect of operational challenges, a number of survey respondents commented on the issue of resourcing/investment in security.

4.45 Some noted a general need for **greater investment** in security to better reflect its importance, to improve safety, to be able to tackle key issues such as violence and aggression, and to be prepared for upcoming issues such as meeting the requirements of Martyn's Law:

> *'More investment in security Trust wide.'*
>
> *(Survey respondent)*

> *'The need for security services and physical security measures to be given sufficient funding and importance within the organisation rather than the lip service it currently gets.'*
>
> *(Survey respondent)*

> *'More money spending on staff, equipment and pertinent training. Support from senior staff.'*
>
> *(Survey respondent)*

> *'Lack of overall support to sponsor security requirements usually ends up in staff being assaulted and or abused by patients/ visitors. In my opinion there is a significant gap in security funding across all NHS sectors, within manned security almost everywhere and somewhere within security systems.'*
>
> *(Survey respondent)*

> *'Consistent level of annual capital investment for physical security improvements. Capital funding being made earlier in financial year so that work can be planned properly rather than the usual year end rush. Revenue budgets for maintaining and repairing security systems should be increased as standard when additions are made to systems.'*
>
> *(Survey respondent)*

> *'Things on the horizon – we want to be able to help the security managers better articulate risk and getting more money in their business cases. Safety and security is everyone's business – but the higher up tend to be clinical and therefore don't understand the issue of safe spaces.'*
>
> *(Interviewee 6 – other security expert)*

[22] In line with the concerns expressed among respondents, barriers/considerations for private security taking on certain Police activities include for example: vetting and proprietary checks; education and training; the need for warranted Police Powers (which Private Security do not currently have); constraints of law (such as carrying of weapons / restraints); constraints of SIA licencing; constraints/implications for private security companies (such as legal action and insurance implications) for undertaking higher risk activities.

4.46 Some respondents noted a need for **investment** in physical security technology (introducing newer technology such as bodycams, and standardising and updating existing measures and systems), and better signage (to explain processes and aid navigation through the site and service, to reduce tensions building). However, a particular focal point for quite a number of respondents, was a **lack of security personnel** – at both the management and the frontline/officer level - which they felt contributed to weaknesses in the overall approach to security:

> *'There is also an issue with staffing numbers – and that the number of security officers per shift has been reduced to save costs. That will also affect the quality.'*
>
> *(Interviewee 9 – in-house security lead)*

> *'Employ more security staff . The hospital was built in the 60's & 70's, there are a lot of fire exits by people taking short cuts and leaving door open. There are a lot of dark areas where people can hide . The CCTV is not manned 24/7 , maybe a maximum of two hours a day Mon- Fri. The main reception desk has three entrances that the public can gain access to the area.'*
>
> *(Survey respondent)*

> *'Further funding to allow a more operationally robust staffing compliment.'*
>
> *(Survey respondent)*

> *'Insufficient resources as only one WTE Accredited Security Management Specialist across two part-time roles to provide a service across the organisation.'*
>
> *(Survey respondent)*

> *'Main issue is not enough resources on security officers especially due to the increase of violence and aggression towards staff. More security would be able to reassure and support staff.'*
>
> *(Survey respondent)*

> *'NEED MORE SECURITY OFFICERS DUE TO THE INCREASE OF VIOLENCE AND AGGRESSION TOWARDS STAFF.'*
>
> *(Survey respondent)*

> *'We have no security guards; the only security is two LSMS's and for one this is not their major role. Funding is needed to bring in security for our mental health and community services.'*
>
> *(Survey respondent)*

4.47 Some suggested a need for creating **specialist individuals or teams** who are specially trained to deal with specific issues such as violence and aggression and mental health patients:

> *'A dedicated security team to manage violence and aggression and searching patients and environments.'*
>
> *(Survey respondent)*

'A&E and the mental health wards are the two places that security is needed the most. Mental health should have a dedicated team – there should be a specialist mental health security officer.

(Interviewee 2 – contract security management)

4.48 Some noted the issue of staffing, as going beyond 'sufficient' investment, to the implications of whether an **in-house model** (i.e. directly employed by their place of work) **or contracted model** (i.e. employed by a security company and contracted to work at that site) is adopted.

4.49 There were two main issues raised in this respect. One was that contracted security staff were **treated differently** to other healthcare staff and that this held implications for their pay and conditions (which had consequences) and in terms of how they are regarded by others:

'By bringing the security team in-house, this may gain the respect they deserve from the clinical staff. It's only after an incident has already happened, then the staff involved begin to respect the security officers.'

(Survey respondent)

'I find in-house security are treated differently to sub-contracted which creates an area of discontent in Security teams.'

(Survey respondent)

'An EPRR officer in the NHS might be grade 7a and that would be generic. I would be surprised given the use of 3rd parties if there is that same level of consistency across the NHS. Is it reasonable to have the same expectations of someone on £15 per hour compared with £20?'

(Interviewee 9 – in-house security lead)

4.50 The other was a view that in-house provision may have **advantages** such as enabling a greater focus on security, greater consistency in provision (i.e. in the skills of officers and how they carry out tasks/techniques) and better quality of staff, and avoiding the pitfalls of procurement processes that focus on buying 'cheap' rather than buying 'quality':

'It starts with the decision whether an in-house NHS model or to outsource security. That's step 1 really and it all links from there.'

(Interviewee 1 – in-house security lead)

'Security role is contracted out and is in the process of being bought in-house where there is a qualified Local Security Management Specialist already employed by the organisation and will be able to allocate more time to the role.'

(Survey respondent)

'Like most Trusts we use contracted security services. They perform an adequate job, but as the contract was re-

newed 2 years ago it was an exercise in finding the cheapest, not the best possible service provider.'

(Survey respondent)

'Bound to have differences between the different locations, healthcare centres, some are in-house, and others are provided by contractors – 3rd party security contractors. To some extent there are some good players, they might have different training standards to other 3rd party suppliers. They may have different qualities of officer. Different pay rates.'

(Interviewee 9 – in-house security lead)

'Currently employ contract security staff. Looking to bring in-house to improve pay and conditions and have full control of recruitment, training, development and management.

(Survey respondent)

'The cost to the NHS of paying the security companies, for how much you pay one security officer in a year, you are paying that in a month. What we are getting back is very little. Private companies, the staff are very basic, maybe no experience, just a body. We've had complaints as well. Behaviour like asking staff for their number, flirting with staff. The quality from external agencies is extremely poor.'

(Interviewee 1 – in-house security lead)

4.51 Conversely however, one interviewee noted that it could be in-house that lacked consistency and standards and that contracted security, via SIA licensing and other standards at least provided a minimum:

'You'll be quite surprised some security people working in the NHS have little to no training. You can have them doing portering and cleaning one minute and security the minute after. I'll give you another scenario. You have hospital A and in hospital A, you have SIA licensed staff. They are trained to restrain, they have done safeguarding, have PPE, body cams, they are competent and know the role. They are checked through DBS – and that for me is where we should be as a minimum across the UK. Hospital B a mile away, has in-house security staff. They may have a dual role – cleaner, porter, security. No SIA licence, they have not been checked that they are fit and proper and have not had right level of restraint training. That is a massive risk for everyone. You need to have the right level of care. Security staff should be part of anyone's care pathway.'

(Interviewee 10 – contract security management)

4.52 One interviewee noted that whether to **extend licensing to those in in-house** security roles was currently under consideration and that if that is introduced, it may bring greater consistency between in-house and contracted security:

'That is something to watch that would help bring consistency – that would impact on healthcare security.'

(Interviewee 7 – other security expert)

4.53 Similarly, a survey respondent highlighted the need for consistency across in-house and contracted security:

'If the SIA audit the trust in respect of the PPB, security staff, whether in-house or contracted with roles and responsibilities, will be instrumental when responding to major/critical incidents.'

(Survey respondent)

4.54 In respect of resources one respondent noted a much more general point about a lack of appropriate places and services for people's treatment needs which has a knock-on effect on the challenges posed for security:

'Stop closing places that can accommodate patients better, stop closing services that can be called to help.'

(Survey respondent)

4.55 Finally in respect of tackling operational issues, survey respondents noted the need for more specialist training for healthcare security and for a national steer to govern security. Since these issues were covered as separate themes within the survey, the views raised have been integrated into the relevant sections focusing on governance (Section 2 - above) and training (Section 5 - below).

Section 5. Training

5.1 Given the additional challenges and complexities of providing security in healthcare settings noted above, and the lack of any current training requirements within healthcare security[23] (beyond the generic baseline set by the SIA licence for those in a relevant licensable role), a number of statements were posed to gauge views on possible ways in which the approach to training of healthcare security personnel may be strengthened.

Possible mechanisms for strengthening training

5.2 Notably, **agreement** with each statement posed was **very high** (around 90% 'agreed' or 'strongly agreed' – of which around 80% **strongly** agreed). There was very little difference in the level of agreement across the statements – all were viewed favourably, suggesting that **addressing training is a clear area for attention**.

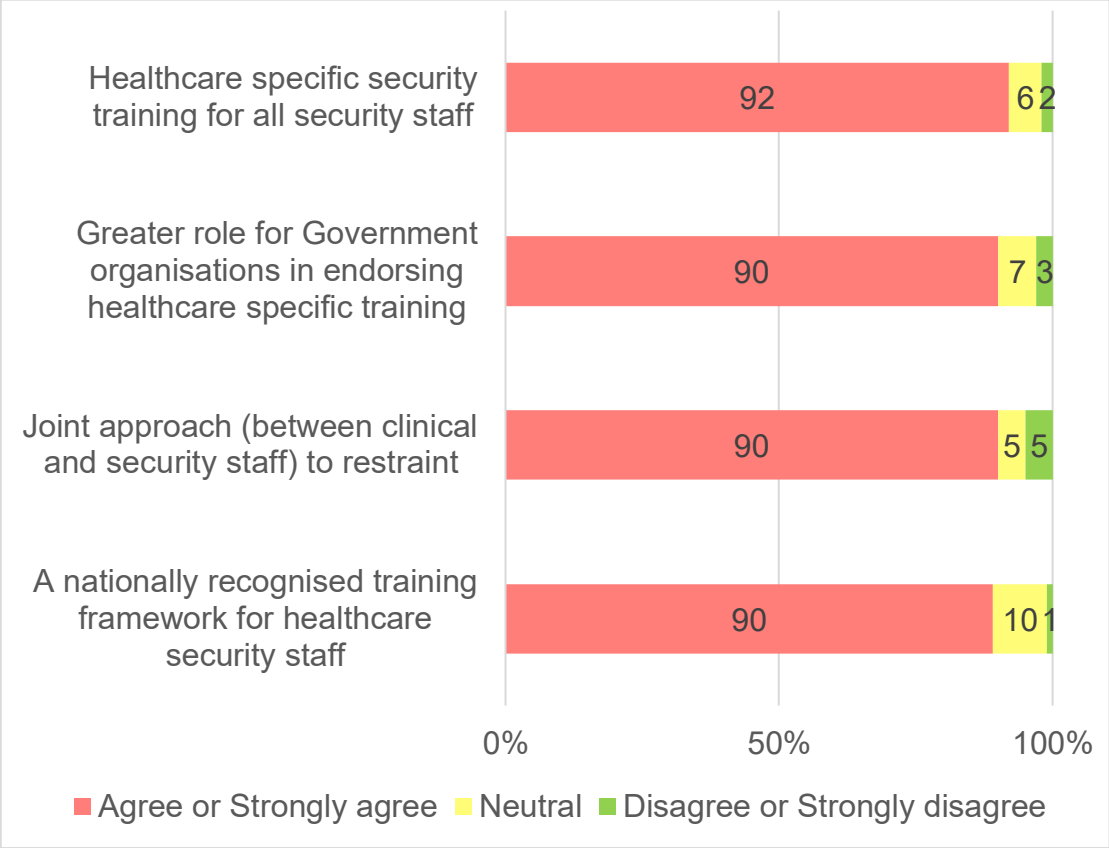
5.3 Specifically, these included that:

- *All security staff should complete **healthcare specific** security training to assess threats and vulnerabilities* (92% agreed or strongly agreed)
- *Where **restraint** (the use of force) is required, there should be a **joint approach** (between clinical and security staff) to ensure that patients' rights and staff safety are maintained* (90% agreed or strongly agreed)
- ***Government** organisations should play a **greater** role in **endorsing** healthcare specific training for security staff* (90% agreed or strongly agreed)
- *There should be a **nationally recognised training framework** specifically for **healthcare security** staff* (90% agreed or strongly agreed)

5.4 The proportions of agreement and disagreement are displayed in Figure 6.

[23] With the demise of NHS Protect the 'Level 5' Local Security Management Specialist vetting and training course ceased to exist. To help address the gap, NAHS has since introduced Level 1 - 3 Healthcare Security Officer training, and Level 5 - Healthcare Security Manager Training. Additional accredited courses are also being developed by NAHS.

Figure 6: Level of agreement with possible ways of improving training for healthcare security personnel (n=105) %



Key considerations for developing the training

5.5 Comments from survey respondents and interviewees explored these potential ways forward for training in more depth and the following key considerations are now considered in turn:

- One national, mandatory model
- Clarity on restraint techniques
- Other knowledge and skills to be covered by training

One national, mandatory model

5.6 A number of respondents re-emphasised the need for consistency nationally, reinforcing the issue raised earlier of a lack of governance to determine the approach. In line with the aspects covered in the survey, there was a general feeling, that every security officer working in healthcare whether in-house or contract **should be trained to a healthcare specialist, specific level** and that this should be **mandatory**:

'A national model that supports the patient's values, but gives the security team staff core training, understanding and support.'

(Survey respondent)

'There needs to be national recognition around the importance of the role and appropriate training to support this.'

(Survey respondent)

'National training standards for all healthcare security personnel with defined career pathways regardless of in-house or outsourced,'

(Survey respondent)

'I am a firm believer training is key. All security officers must reach a minimum standard of training and must sit a Healthcare security officer certificate, this should be at a recognised level to show a level of understanding and competence. Healthcare security does stand alone, and security officers need to be professional and have a full understanding of the role of a healthcare security officer. This is not the role of a narrow minded individual.'

(Survey respondent)

'All training mandatory and relevant to the role,'

(Survey respondent)

'All training should be mandatory and in English. If training is not complete, then the job role should go to someone who is willing/able to complete it. All security job roles/SIA applicants should also have an English-speaking test as I find in my role that I cannot understand some of the officers due to language barriers. As much as I appreciate the efforts they put into their job role, if I cannot understand what they are trying to say to me, I cannot do my job correctly and this then reflects on myself and my team.'

(Survey respondent)

'There should be a baseline – you need to have a licensing criteria – anyone working in security should have an SIA licence which gives them the basics – role, then DBS checks, safeguarding, CT stuff. All the basics for someone in security. There is nothing at this moment in time for those that work in security. What can I apply from SIA to make me trained to do that. DS licence is not relating. Needs to be something really specific.'

(Interviewee 10 – contract security management)

'They need custom built training to understand the current workplace – SIA just doesn't do that for healthcare. Learning outcomes aren't suitable for other types of environment other than night-time economy from my experience.'

(Interviewee 6 – other security expert)

'In an ideal world, if we had an overarching body, it would say that if you want to be healthcare security, do step 1. This teaches everything you need to know about combining clinical and restraint. That would be fantastic. In the NHS, there are competing models. A lot of people making money from supplying training packages. It would be good to have one unified approach. This is how you train a police officer – it's the same for everyone. Maybe if it was like that.'

(Interviewee 1 – in-house security lead)

5.7 Quite a number of respondents felt there was **a case for a specific SIA licence** (and therefore training) **for 'healthcare'** that would be a requirement for all officers working in healthcare settings[24]:

'A dedicated healthcare licence to meeting challenges attributed to healthcare environments i.e. dementia, vulnerable young people, lockdown, protection of premises, Use of Force Act etc.'

(Survey respondent)

'An SIA accredited licence of its own thus ensuring that during the recruitment process, the job specification is an essential requirement or must work towards one. Until accredited, the employee would not be permitted to attend violent incidents, monitor CCTV etc.'

(Survey respondent)

'Healthcare security related SIA licence. DS licence is a good foundation, but the PI trained in it is not wholly appropriate for healthcare security, whereas it is for clubs and pubs etc.'

(Survey respondent)

'I would look at a joint course between BILD Certificated training and SIA Licensed training specific to Healthcare Security. A course that combined the two elements could be shared by Security Officers and Nurses, which would support greater understanding and cohesion between the two professional groups.'

(Survey respondent)

'I've worked in health and private security industries and although there are benefits from the SIA training from legal framework perspective, it doesn't prepare security staff for a healthcare role. In particular the physical intervention training offered by the SIA door supervisor role is laughably sub-par in relation to a healthcare role with the argument that it's not fit for purpose in a licensed establishment either

[24] There is no healthcare specific licence, however the SIA has been reviewing the licence-linked qualification, and a number of aspects that are pertinent to the issues raised here (such as safety-critical skills and physical intervention techniques). Further, the forthcoming SIA Business Assurance Scheme (replacing the Approved Contractor Scheme) is expected to include sector-specific requirements, one of which is healthcare.

but in the absence of anything else there is a huge gap. I would call upon a health sector license with more bespoke training to manage clinically related challenging behaviour.'

(Survey respondent)

'The SIA licence is not enough and only geared for Door Supervisor - a full training package - under licence - should be identified for security healthcare operatives so enabling them to be able to professionally respond to the many different types of patients that arrive at our hospitals.'

(Survey respondent)

'If you think of the current 6-day SIA training, there is a lot to be said for having an additional module that gives you sector specific training. It is highly relevant for healthcare and sectors like universities – that work out of hours and deal with people with emerging mental health issues. If you have an additional module, that makes life easier in terms of what you can expect someone to be capable of doing.'

(Interviewee 9 – in-house security lead)

'A specific healthcare security licence that is applicable to patients and service users of mental health services.'

(Survey respondent)

'We need a minimum standard – create a specialist team that can be specialist mental health nurses with a security licence, but you have to pay for it.'

(Interviewee 3 – contract security management)

5.8 One interviewee (an 'other' security expert) suggested that in the absence of a specific SIA licence, creating an accredited course for healthcare may be sufficient if there was a way to enforce it as the required standard.

5.9 There were some suggestions in terms of **how the model should be structured**, such as how often the training should be revisited:

'Every security guard whether contracted or employed directly by NHS should have a recognised certification that they are trained to an agreed standard and can demonstrate correct restraint techniques etc. Should be reviewed annually / bi-annually.'

(Survey respondent)

'National mandatory qualification for healthcare security staff - this could be combination of initial training for security staff new to healthcare with CPD to be completed within say 3 - 6 months. SIA PSS CCTV qualification should be mandatory for all healthcare security staff working in controls, whether they are in-house or contract. NHS should approach the National Protective Security Agency to develop their Major Incident Control

Room training tailored to acute hospitals and affordable - current rates are not affordable in current financial climate.'

(Survey respondent)

'The training time is laughable – a day of physical intervention training for an officer on a SIA licence, and it's a perishable skill. It's part of a 6-day DS course and they expect them to retain that knowledge for 3 years. It's not going to be sufficient. They should be having 6 monthly refreshers.'

(Interviewee 9 – in-house security lead)

Consistent restraint techniques

5.10 Unsurprisingly, given the findings above in respect of the levels and challenges of dealing with violence, **restraint/physical intervention** training was seen as **essential**. Moreover, respondents commented on the need for **consistency nationally, within healthcare, in respect of the techniques used for restraint**. Indeed, one interviewee explained the danger that currently individuals could be trained in different techniques and therefore try to apply those different techniques in a single situation (given that restraint has to be undertaken by more than one individual):

'The second issue is the way the training is delivered – there's no one agreed methodology. Different training providers – whoever you wish to use have different methods. So, you will have officers that have trained under different methods. So, for restraint you have two security officers doing it – potentially in a scenario one person could do it one way, while the other is doing it another a different way. They are each competent, but it is not teaching the same technique. That is something that should be addressed. At the moment that is abdicated to the training providers. You could have people obtained licence from different trainers and trained in different methods. Physical intervention only works doing it in a team – two as a minimum. On your own is nigh on impossible. To do it safely you need two people minimum.'

(Interviewee 9 – in-house security lead)

'One training system rather than too many varying models of restraint, this would be a nationally recognised system i.e. BILD accredited to ensure whatever system is adopted meets the current criteria. Again, national instructors (military model) would work well within the NHS as it does with in UK armed forces.'

(Survey respondent)

'Set up a national taskforce to create best standards.'

(Survey respondent)

5.11 Related to this, one survey respondent highlighted **confusion** in respect of whether there is a requirement to adopt **Restraint Reduction Network practices** which they felt also needed clarification:

> *'Clarity regarding the Restraint Reduction Network [RNN]. I attended a seminar put together by them and we were told in no uncertain terms that as security officers working in an NHS acute hospital we would have to follow the RRN training standards and that the SIA also demanded this. This would have caused us huge logistical problems, and massively reduced the effectiveness of our skills to manage violence and aggression. We brought in an external consultant [named], who reviewed our training, confirmed it was of a high standard, and confirmed that the RRN standards do not apply to us, although many of their principles would be beneficial if we followed them, which we did after he mapped them into our training. All good, but we are still being told that we must be RRN trained.'*
>
> *(Survey respondent)*

5.12 One interviewee also raised a broader concern that the methods of physical restraint taught as part of the current SIA licence are not appropriate in a healthcare setting, and therefore it was not just a case of ensuring consistent techniques are used, but ensuring the techniques chosen are **appropriate to the environment**:

> *'[SIA] Training on physical restraint is not fit for purpose. It uses a series of low-level techniques to deal with attacks that are unrealistic – wrist grabs, etc. That is not equipping security officers with what they need. Kicks, strikes, punches. I don't know why the training wouldn't mirror the training the police get – there is no reason why those techniques can't be used. It is far better that they are trained to use them than doing their own thing. Healthcare is far more complex than just about any other scenario. It could be part two of a fight in A&E that started in a nightclub. Now they are having round two and the security team is expected to deal with that. Or it could be a dementia patient assaulting a nurse – there is a completely different approach and method required for that. It's a difficult set of scenarios they are dealing with.'*
>
> *(Interviewee 9 – in-house security lead)*

Other knowledge and skills to be covered by training

5.13 A number of respondents commented on **other knowledge**, such as **legislation**, that they thought was important to include in the training, for example:

> *'They need to understand the law and what they can and can't do – that's critical. Security staff can't lay hands on*

mental health patients in my organisation – staff do that - they don't know the safe holds. They need to know and understand their responsibilities and roles. What makes the NHS the NHS. How they present themselves. We want them to be professional and be able to engage, but also it's difficult.'

(Interviewee 5 – in-house security lead)

'Understanding of MHA/MCA[25], DoLS[26], RCRP[27] and common law.'

(Survey respondent)

5.14 Respondents noted the importance of understanding the early **signs** of violence and aggression and **de-escalation** skills so that physical intervention is only used as an exception/last resort:

'More emphasis on de-escalation, breakaway, and physical intervention training with a focus on non-restraint techniques and verbal de-escalation.'

(Survey respondent)

'Physical intervention with patients should be by exception only.'

(Survey respondent)

'They need training. The British Institute of Learning (and associated network) are arguing on disability there should be less restraint, and restraint should be the last option. The real skill here is about de-escalation skills and using verbal skills, and trying to segregate and so it is about other things before restraint and so we are aligned here.'

(Interviewee 4 – in-house security lead)

5.15 Indeed, one interviewee noted they use a de-escalation management and intervention training package which is an accredited programme and have extended the training to some clinical teams as well as security to improve cohesion and consistency:

'It's really good. That is delivered to officers. It follows de-escalation, with restraint and physical contact as a last resort. We don't use soft cuffs or anything like that. That's still a big question. There are others that will do that. Our officers get annual refreshers. What we have done to build that relationship with clinical teams is all ED staff receive the same training. EPO staff. A lot of frontline staff have had the training. The reason why we've done that is so they understand safe restraint, that they may need to do clinically, or support officers. The major thing is it creates understanding of what is expected of everyone, why is security doing that, why is clinical staff doing that. There will always be that odd time where there's a

[25] Mental Health Act / Mental Capacity Act
[26] Deprivation of Liberty Safeguards
[27] Right Care Right Person

misunderstanding or a difference of opinion of whether it's been used too soon or been allowed to go on too long, but those have reduced. There is a better relationship and awareness of what everyone is doing.'

(Interviewee 1 – in-house security lead)

5.16 **Clinical awareness** such as how to address situations where there is a clinical need such as **mental health and dementia** were also flagged as well as specifically how this related to violence and aggression and restraint:

'Increased training on clinical duties including Dementia, Mental Health and Neuro-Divergent training.'

(Survey respondent)

'Ensure that security staff have the opportunity to work clinically and receive mental health training.'

(Survey respondent)

'Incorporate more clinical understanding and medical understanding.'

(Survey respondent)

'For all officers to receive a Maybo / ikon style mental health training and how to deescalate patients that are showing violence and aggression due to having a mental health episode, as well as spotting signs of mental health episodes as well as mental health illnesses.'

(Survey respondent)

'We give officers Maybo training – clinical safer holding. Every healthcare security officer has that as a minimum. But there is a cost – people won't pay more. I want them to have behaviour detection for example but it's an added cost.'

(Interviewee 3 – contract security management)

5.17 The importance of **communication skills** was also noted:

'We need to have people who can communicate, from different backgrounds, different lived experiences and remain calm and problem solve. For me it's that and the ability to not just communicate but to actively listen … conflict management is about communication – getting in early when signs of aggression are starting. Also need patience and empathy.'

(Interviewee 6 – other security expert)

'We learnt quickly, and I think we've got a different approach to security in healthcare. We believe it's softer skills that are needed. Not stab vests and baseball caps. If you go hands on, we see that as a fail. We need to use communication skills, listening skills, if an officer is not having success, swop them out with someone else so it doesn't escalate. That's the approach we should be taking. Training and innovation. Always a drunk in A&E – with that

it's the softer skills, communication skills, walk them out, deal with them away from innocent people.'

(Interviewee 2 – contract security management)

'Language barriers need addressing.'

(Survey respondent)

5.18 Finally, the need for specific training on **security leadership skills** was also noted, but has not been considered here, having already been addressed under the section on Governance above (Section 2).

Section 6. Discussion

What does all this mean?

6.1 This study of security personnel working in a healthcare setting is long overdue. While it was inevitable that the disappearance of NHS Protect and the governance structure it provided would leave a gap, what this study has revealed is that that gap **remains**, the gap is **wide,** and the consequences are **far reaching**.

6.2 We should be clear that in studies like this it is not unusual for respondents to lament the lack of resources, and/or the lack of response from the police. Recently in the UK similar challenges have been publicised by other sectors such as retail. What is striking is the **consequences** in healthcare, unlike retail, have largely been **under the radar**. At least until now.

6.3 Respondents felt there is a **lack of understanding** of security in some healthcare organisations, linked to a lack of senior level oversight and support; security personnel, measures and equipment are sometimes managed by a security manager that is a 'generalist' (not a security specialist); and sometimes procured/specified by other departments (again not security specialists).

6.4 As a consequence, the security needs of those organisations are **poorly defined** and there is **confusion** about what security do and what powers they have. Security personnel are not given the **direction** they need, not **trained** appropriately and are not **supported** by others, but are facing some of the most **challenging** environments with daily violence and aggression affecting their organisation reported by many. And in some cases, they are expected to undertake additional tasks that require clinical knowledge/accreditation. But security personnel are not applauded for doing their best in difficult circumstances – they are **criticised** for their lack of skills and their handling of incidents. Moreover, as a consequence staff (including security) and patients are put at **risk**, and policies and legislation are being breached, opening up individuals and organisations to significant consequences, not least legal action.

6.5 The incoming Martyn's Law[28] (and the requirement to prepare) gave some respondents hope that security would start to be taken more seriously. However, it was clear that a number of **actions** are needed to address the neglect that security has suffered from, to **position** it appropriately for the significant **demands** of operating in healthcare environments and to re-frame security within healthcare organisations as an **enabler of patient care**.

[28] The Terrorism (Protection of Premises) Act 2025

What is required?

A national governance structure

6.6 Respondents craved a **consistent** approach across every aspect of security – how it is overseen, managed, staffed, equipped and procured; what tasks are carried out, who can do this; what they need to know and what they should be paid.

6.7 Respondents felt this could only be achieved through a national governance structure, **mandating** the approach to security, setting the standards and providing ongoing oversight, to ensure healthcare organisations take responsibility. It was clear that a governance structure (if well designed) would have a positive impact on many of the challenges faced.

6.8 Respondents were particularly keen for a joint approach and joint training (with clinical staff) to be defined, in respect of the approach to violence and aggression and the **use of restraint**, in order to overcome a key area of misunderstanding of their role, clarify expectations and improve staff and patient safety. Moreover, they are seeking a **tightening of the boundaries** of the role so that security personnel are not pushed into tasks that are inappropriate, both so they can focus on their primary purpose and to ensure their safety (and job security), the safety of patients and ultimately to abide by policy and legislation.

6.9 Respondents were also in favour of **central collation** of healthcare related security incidents to **ensure understanding** of patterns and trends nationally and **respond** accordingly as issues develop and emerge.

Nationally recognised healthcare specific training framework

6.10 Respondents were clear that healthcare security is a **specialist** area of security, requiring a **distinct set of skills** in addition to the current baseline security skills, in order to properly equip them for the role, reflect the challenges involved, and make the role into a '**career**' (thereby also addressing some of the recruitment and retention challenges).

6.11 There was a strong view that **all** security staff, whether in-house or contract, should complete appropriate healthcare specific security training. Further, that **security leaders** within healthcare must do the same (appropriate to their level) and become specialists in order to garner the respect needed and be able to **advocate** for security.

6.12 Mirroring the views on governance, the majority viewed a **nationally recognised training framework** specifically for healthcare security staff, as the appropriate route for taking this forward. Quite a number felt there was a case for a specific SIA licence (and therefore training) for all officers working in healthcare settings.

6.13 Respondents emphasised the importance of skills on relevant **clinical awareness, relevant legislation, appropriate restraint techniques**, but also **de-escalation skills** so that physical intervention is an exception/last resort. There was a view that restraint techniques in particular need **clarity and consistency** to remove the current dangers that can arise from different staff being taught and applying different techniques at the same time. The techniques agreed must also be **appropriate** to the scenarios experienced in healthcare environments.

Engaging with the Police and managing without them

6.14 The level of violence and aggression occurring in healthcare organisations and a reduced response from the police (particularly in light of recent changes in respect of 'Right Care, Right Person' for Mental Health patients) **necessitates further thought** about how healthcare security engage with the police and how they manage when the police cannot respond. This is currently a broader conversation within the security sector, and it is **critical that healthcare security stay close** to this.

6.15 Respondents identified a need to **develop better relationships** with the police, to build a rapport and identify productive ways of tackling issues, and again this linked back to the issue of governance (and clarity on how the police and healthcare security should work together). They noted the importance of **reporting** incidents, so the police have a true picture of the scale of the issues affecting healthcare sites.

6.16 It was also evident that there is a reality that the police cannot always be there, they have to prioritise, and they face their own resource constraints. Respondents were **less clear** on how to fill this gap, and further consideration is needed to determine the best way forward. Enhancements to security such as further training, powers and/or equipment were mooted, although some were concerned that any new approach needed to be **appropriate** to the abilities of security staff and conducive to a healthcare environment.

Staffing security

6.17 As noted above, it is not uncommon for security professionals (in all sectors) to highlight the need for greater investment. What is striking here is that the levels of violence and aggression in the healthcare sector create a **huge financial burden** for the NHS[29] which necessities action. Developing the approach and investing in training to better prevent and respond, seem an obvious way of reducing violence and aggression, which would benefit patients and staff and reduce the financial burden, **freeing up resources** to be put to better use. Indeed, the need for more

[29] Violence, aggression and abuse against NHS staff is estimated to cost the service over £83 million annually in legal fees, compensation, and staff turnover – see for example - https://www.bma.org.uk/news-and-opinion/the-effects-of-workplace-violence

security staff/resources highlighted by some may be resolved, if the levels of incidents can be brought down.

6.18 Again, linking back to the issue of governance, respondents indicated there is a need for further thought about **appropriate staffing models** (e.g. in-house v outsourced) and a better approach to **buying security** services, measures and equipment to avoid organisations prioritising **cost over quality** and ensure what they put in place is effective. As noted above, the importance of **involving** security specialists in buying decisions was highlighted. And **addressing the pay** was seen as essential to attracting and retaining the right calibre of personnel.

Appendix 1 – Methods

A targeted background literature review was undertaken to identify key issues to inform the consultation. Consultation was then undertaken with relevant stakeholders via two main methods: an online survey and one to one interviews. This was followed by quantitative and qualitative analysis.

Online survey

The survey was promoted among NAHS members. The findings are based on 122 responses[30]. The majority of questions were multiple choice, some of which posed statements which respondents were invited to score to reflect their own opinion. A small number of questions invited open text responses.

In addition to the frequency responses to questions, analysis was undertaken to assess whether views differed by specific characteristics/sub-groups of respondents (such as sector, organisation type, role, employment type, region). On the whole the comparisons were not statistically significant (i.e. cannot be determined as evidencing a relationship between the variables and may occur by chance). This is likely to be due to some answer options having very low numbers of respondents with those specific characteristics.

Throughout the findings, percentages are used to describe the balance of opinion. The number of responses relating to each percentage has not been stated (to aid readability)[31] but the total number (n=) answering the question can be seen for reference in corresponding graph and table headings.

Survey sample

The survey was primarily aimed towards and therefore answered by security professionals, but NAHS members in other roles with an interest in healthcare security were also invited to contribute. Close to two thirds of respondents (65%) were in a security 'leadership' type role (i.e. 'Director', 'Head of Service' or 'Manager'). The full breakdown of respondents by role is shown in Table 3.

Table 3: Breakdown of respondents by role % (n=122)

Role	%
Security Head of Service	33%
Security Manager	29%
Violence Prevention Reduction Lead	10%
Security Officer	8%
Security Director	3%

[30] Responses received where none of the main survey questions were answered were removed from analysis. The number of responses to each question varies as some respondents dropped out part way through and some chose not to answer certain questions.

[31] Further, since there were typically between 100 and 122 responses to each question, the 'n' holding a particular view is similar to the percentage stated.

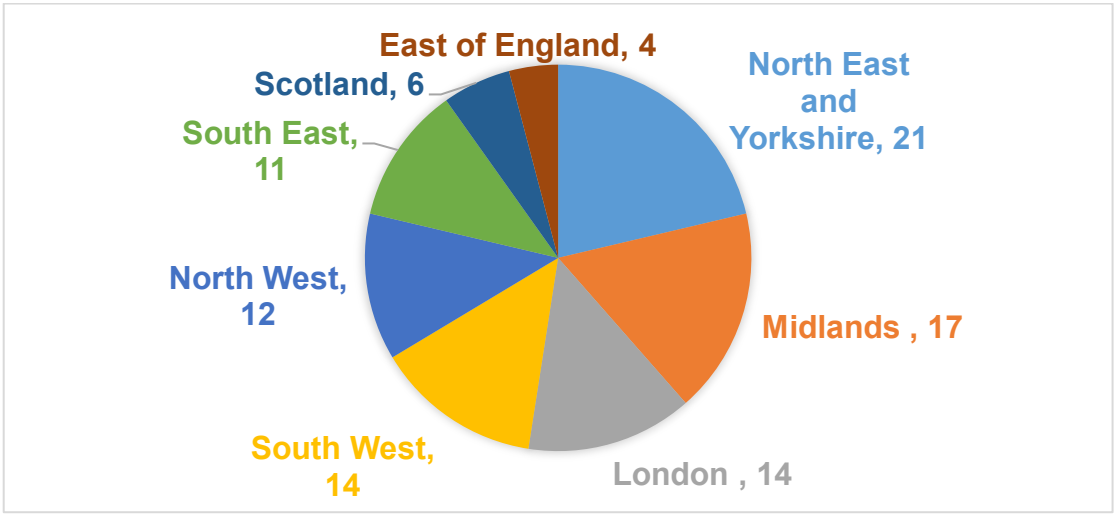
EPRR	1%
Clinical	1%
Other[32]	16%

The majority of survey respondents were employed 'in-house' (80%).[33] Over a quarter (28%) indicated they hold an SIA licence.

The majority of respondents indicated they work for the public sector (89%)[34]. Close to two thirds (65%) work in an acute hospital and 15% work in a mental health service[35].

Respondents represented all regions of the UK, except Wales and Northern Ireland (and no respondents were based overseas). The distribution is displayed in Figure 7.

Figure 7: Region respondents are based in (n=122) %



Given the details of participants outlined above, it should be noted that the survey findings will therefore naturally most strongly reflect the views of those involved with public sector, acute hospitals, in an in-house capacity and in a security 'leadership' capacity. That said, it should be borne in mind, that while that reflects participants current demographics, their views could also be influenced by experiences from a range of roles.

[32] Examples of 'other' roles included Security Advisors, Health and Safety Advisors, Trainers, Facilities leaders.
[33] 18% were 'contracted' and 2% indicated 'other'.
[34] 8% (n=10) work for the private sector, and 2% (n=2) work for the third-party sector.
[35] 5% (n=6) work in a community hospital; 2% (n=3) work in ambulance/patient transport and 2% (n=3) work in a community/GP practice. 11% (n=13) indicated 'other' – of these the most common explanation was working across a range of sites.

Interviews

One to one interviews were undertaken to explore key issues arising from the survey responses in order to provide more depth to the survey insights. We spoke to 10 individuals from a range of perspectives including those working within security healthcare (in-house and contract), and other security experts in a related role. Within the findings attributors have been included alongside quotes from interviewees to give some context to the perspective of the interviewee, however attributors have been generalised in order to provide anonymity.

About Perpetuity Research

Perpetuity Research is a leading research company with wide expertise in both quantitative and qualitative approaches. We have been extensively involved in evaluating 'what works' (and what does not). Our work has involved helping our clients to understand people's behaviours, perceptions and levels of awareness and in identifying important trends. We have also developed a tailored framework for articulating value in areas (such as security) where contribution is recognised but rarely measured effectively. This is a field in which structured, credible approaches to evidencing value have historically been limited.

Our mission statement is 'committed to making a difference', and much of our work has a practical application in terms of informing decision-making and policy formulation. We work closely with businesses, national and local governments, associations and international organisations as well as charities and foundations. Our aim is to exceed their expectations and it speaks volumes that so many have chosen to work with us repeatedly over many years.

About the Authors

Professor Martin Gill

Professor Martin Gill is a criminologist and Director of Perpetuity Research which started life as a spin out company from the University of Leicester where he holds an honorary Chair. Martin has been actively involved in a range of studies relating to different aspects of security, private policing and business crime on topics including: organised crime and fraud; why offenders offend; the (in)effectiveness of different security measures; and the scope of security management. Martin has been extensively involved with evaluation research and with the offender's perspective looking at how they target certain people and premises and aim to circumvent security measures. He has published 15 books including the third edition of the 'Handbook' of Security' which was published in 2022. He is the organiser and Chair of the Security Thought Leadership webinar series. Martin is a Fellow of The Security Institute, a member of the Company of Security Professionals (and a Freeman of the City of London). He is a Member of the ASIS Global Board of Directors and a Trustee of the ASIS Foundation. In 2002 the ASIS Security Foundation made a 'citation for distinguished service' in 'recognition of his significant contribution to the security profession'. In 2009 he was one of the country's top 5 most quoted criminologists. In 2010 he was recognised by the BSIA with a special award for 'outstanding service to the security sector'. In 2015 and 2016 he was nominated and shortlisted for the Imbert Prize at the Association of Security Consultants and in the latter he won. In 2016 ASIS International awarded him a Presidential Order of Merit for distinguished service. In 2022 he was recognised by *Security Magazine* as one of the 'Most Influential People in Security' and also received the Mervyn David Award from the ASIS UK Chapter 'for his significant contribution to the security profession'. In 2016 he was entered onto the Register of Chartered Security Professionals. Martin is the Founder of the Outstanding Security Performance Awards (the OSPAs and Cyber OSPAs); the Tackling Economic Crime Awards (the TECAs); the Security and Safety

Entrepreneurial Awards (the SSEAs); the Fire and Resilience Awards (the FREAs); the Workplace Violence Reduction Awards (the WVRAs)' and the Outstanding Loss Prevention Awards (the OLPAs).

Charlotte Howell

Charlotte has over 15 years' experience in crime and security research and holds a first class LLB (Hons) in Law and an MSc in Criminology. Charlotte's role as Research Manager encompasses responsibility for managing the delivery of research contracts, and our team of research staff. She also manages the Secured Environments scheme run by Perpetuity Research on behalf of Police CPI, auditing organisations in respect of their security management practices. Charlotte is an accomplished project manager with experience of working with a range of clients including businesses, associations, police forces, government organisations and charities. Charlotte has delivered a range of projects for example relating to: the work of security officers, careers in security, women in security, offenders views of security measures, the benefits of security, security culture, prison security managers, the needs of victims of crime, hate crime, domestic abuse, financial investigation, serious acquisitive crime and violent crime. Charlotte has consulted with a range of individuals, including stakeholders (such as individuals from the police, security professionals, local authorities, service commissioners and staff), offenders (both in prison and in the community) and clients accessing services (such as drug and alcohol treatment services, domestic abuse services and support services for sex workers). Charlotte is adept at quantitative and qualitative analysis and has a wealth of experience analysing survey responses, client/service data, performance/outcomes data, literature and interview findings.

Dr Janice Goldstraw-White

Janice is a criminologist who has been affiliated with Perpetuity since 2010, with specialised expertise in crime, governance, audit, risk management, and security. Building on over two decades of prior experience as an accountant, her research particularly centres on workplace crime, offender behaviour, and the role of women in financial offending. Her primary research interest lies in economic crime, which she has investigated extensively in both the UK and Australia, with a specific focus on offender narratives. She has conducted over fifty interviews with incarcerated white-collar offenders and has substantial experience conducting qualitative research within custodial settings. Janice's methodological expertise is grounded in qualitative approaches, including literature and policy reviews, institutional and procedural mapping, interviews, and focus group facilitation. She also possesses a sound working knowledge of quantitative methods and data analysis. She has led and contributed to a wide range of research projects addressing issues such as fraud in local government, the case for mandatory fraud reporting in the UK, digital evidence challenges, responses to fraud victimisation, NFT fraud, and cross-sector collaboration to combat economic crime. She is currently researching the level of support to organisations for business crime and how to share data more effectively. Her work also extends beyond economic crime to include studies on

organised crime in the private rental sector, the disproportionate impact of COVID-19 on security personnel, data centre security, the integration of AI into security practices, and the development of sector-specific key performance indicators. She is currently engaged in a study examining how the value of security can be effectively demonstrated to stakeholders. Janice has authored and co-authored multiple peer-reviewed publications and book chapters, most recently on female perpetrators of fraud. Her own book, White-Collar Crime: Accounts of Offending Behaviour, was published in October 2011.



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