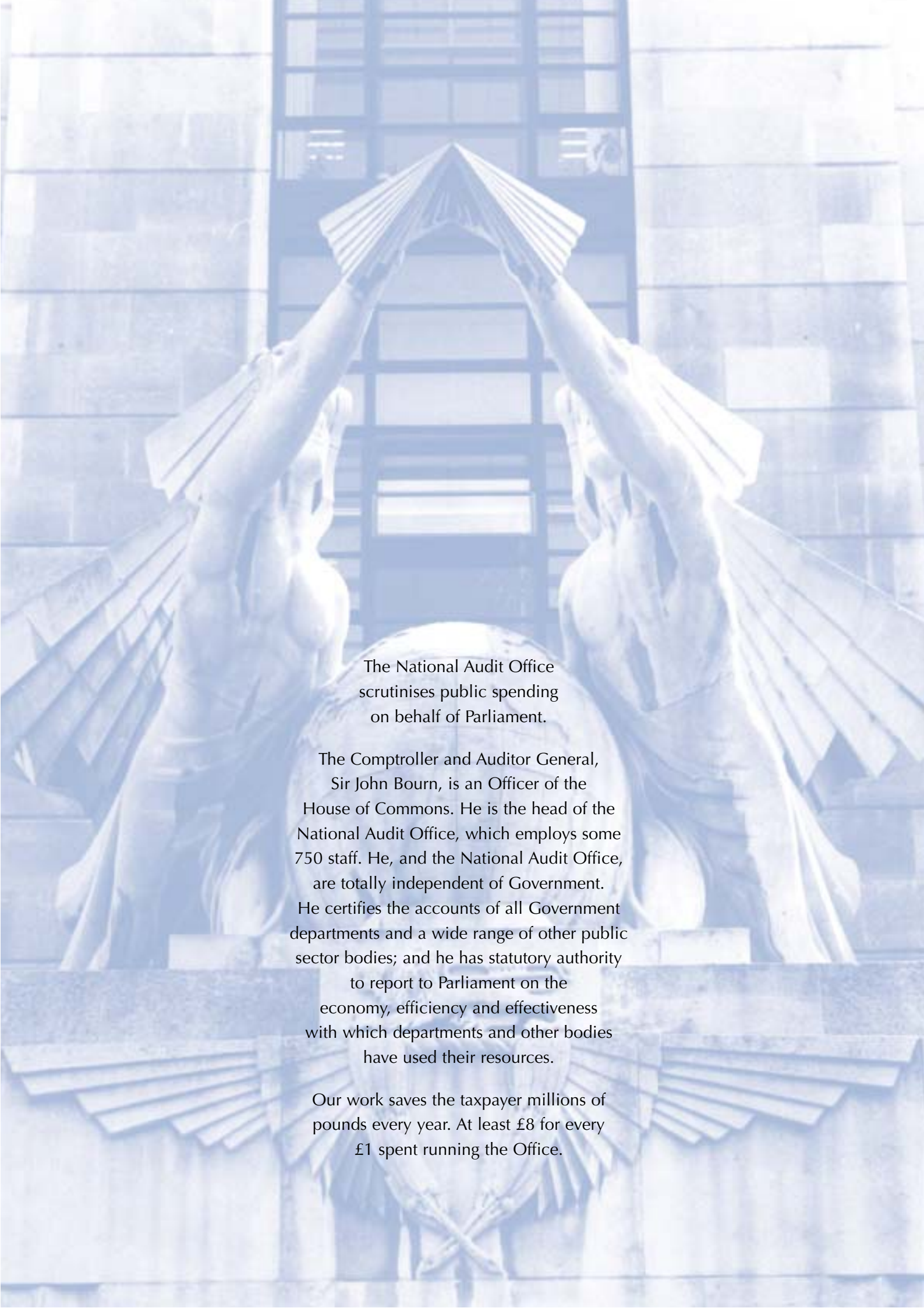
NATIONAL AUDIT OFFICE

A Safer Place to Work

Protecting NHS Hospital and Ambulance Staff from Violence and Aggression

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
HC 527 Session 2002-2003: 27 March 2003



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John Bourn
Comptroller and Auditor General

National Audit Office
21 March 2003

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executive summary

1 The National Health Service (NHS) is Europe's largest employer, employing more than one million staff[2]. NHS staff have the right to expect a safe and secure workplace and NHS organisations have a legal and ethical duty to do their utmost to prevent staff from being assaulted or abused in the course of their work. The 2000 British Crime report, however, found that nurses are up to four times more likely to experience work-related violence and aggression than other workers[3].

2 In November 1996, our report, and the subsequent Committee of Public Accounts report, on *Health and Safety in NHS Acute Hospital Trusts in England*[4,5] highlighted concerns about the burden of accidents on the NHS, including violence and aggression, and the lack of information on the extent of incidents and their costs **(Appendix 1)**. Since then Secretaries of State for Health have made reducing levels of violence and aggression a priority for all health service managers. In turn, the Department of Health (the Department) has taken action to improve the management and monitoring of health and safety risks[6], and issued comprehensive guidance, including examples of good practice, for reducing violence and aggression **(Appendix 2)**.

"Aggression, violence and threatening behaviour will not be tolerated any longer."

John Denham, the then Minister of State for Health, launching the NHS zero tolerance zone campaign in October 1999[1]

3 We have examined the progress made since 1996. Our report, *A Safer Place to Work - improving the management of health and safety risks to staff in NHS trusts*, (which will be published in April), looks at the management of the wider issues of health and safety risks to staff. This report examines the extent and impact of violence and aggression within the NHS (which in 2001-2002 accounted for 40 per cent of all health and safety incidents reported to us) and evaluates the effectiveness of the actions taken by the Department and NHS trusts[7]. An over-view of our methodology is at **Appendix 3**.

4 Together the two reports provide a comprehensive view of how well NHS acute, mental health and ambulance trusts are doing in reducing health and safety risks to their staff.

Main findings

5 Two initiatives, launched in October 1999, have been key to tackling the growing concerns about the level of violence and aggression in the NHS:

- the NHS *zero tolerance zone* campaign[8], which had the support of the Home Secretary, the Lord Chancellor and the Attorney General was aimed at increasing staff awareness of the need to report, assuring staff that this issue would be tackled and informing the public that violence against staff working in the NHS is unacceptable and would be stamped out; and
- *Working Together, securing a quality workforce for the NHS*[9], required NHS trusts and health authorities to have systems in place for recording incidents using the standard definition below and set targets for reducing violence and aggression by 20 per cent by 2001 and 30 per cent by 2003. The targets were subsequently incorporated in the *Improving Working Lives*[i] standard, launched in October 2000, which all acute, mental health and ambulance trusts were required to put into practice by April 2003[10].

Violence - "any incident where staff are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well being or health"

- European Commission DG V 1997

Source HSC 1999/229[7]

6 As part of the *Working Together* initiative the Department undertook two national surveys. Their 2000-2001 survey identified 84,214 reported incidents of violence or aggression, an increase of 30 per cent over 1998-1999[11]. Our 2001-2002 survey showed a further 13 per cent increase (to 95,501 reported incidents) and significant variations around the country **(Figure 1)**. Reasons given include better awareness of reporting with more widespread use of the common definition which includes verbal abuse, but also increased hospital activity, higher patient expectations and frustrations due to increased waiting times. As a result, only a fifth of NHS trusts met the *Working Together* target of a 20 per cent reduction by April 2002. This increase in reported incidents of violence in the NHS is mirrored by an increased tendency to resort to physical and verbal aggression in society more generally[3].

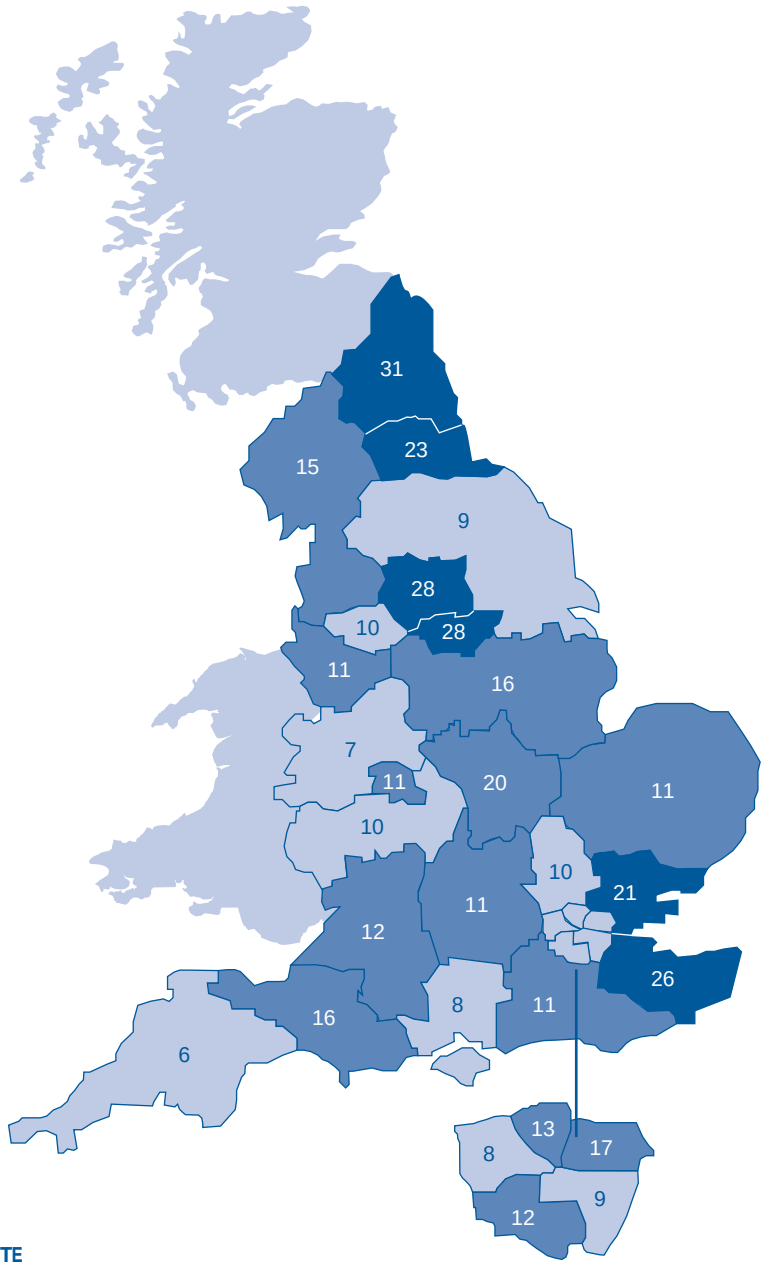
7 Nurses and other NHS staff who have direct interaction with the public, for example, ambulance and accident and emergency staff and staff who work in acute mental health units, have a higher risk of exposure to violence and aggression[3,12]. In particular, the average number of incidents for NHS mental health and learning disability trusts is almost two and a half times the average for all trusts, despite evidence that staff working in mental health units are much less likely to report verbal abuse[13].

8 The NHS *zero tolerance zone* campaign[8] has been developed and implemented in partnership with the trade unions in the health sector and good progress has been made in raising awareness and disseminating good practice. Whilst all NHS trusts have embraced the values set out in the campaign there has been mixed success in encouraging staff to report incidents. Wide variations in reporting standards, different definitions and continued under-reporting, make it impossible to say conclusively how far the increase in reported violence reflects an actual increase in incidents, or measure how trusts, individually and overall, are performing. There also remains a high and varied level of under-reporting of incidents (which we estimate is around 39 per cent).

9 Reasons given by staff for not reporting incidents include concern that the incident might be viewed as a reflection of their inability to manage the incident, not wanting the attention any action might bring and forms being too complicated or inappropriate for recording what happened. Staff also fear that no action will be taken or that the NHS trust is unlikely to give them adequate support. Staff surveys also indicate that a lack of feedback on actions taken to deal with or reduce incidents discourages reporting[14,15].

i The Working Together targets and the Improving Working Lives initiative were subsequently incorporated into the HR in the NHS plan, launched in July 2002, the Government's workforce strategy for the NHS.

1 The average number of reported incidents of violence and aggression per 1,000 staff per month in 2001-2002, shown by Strategic Health Authority



NOTE

The average number of incidents per 1,000 staff per month in 2001-2002 is 14 for all Trusts and 33 for Mental Health Trusts (Figure 4). Strategic Health Authorities with incident levels of 20 or more all contained one or more Mental Health Trusts.

Source: National Audit Office survey of Trusts

10 A number of research projects have demonstrated clear links between violence and aggression and staff sickness absence, turnover and lost productivity[16,17,18], but there is no consistent NHS trust data on this making it difficult to quantify the impact on, and cost to, the NHS. International research aimed at estimating the cost of workplace violence and stress concluded that there were too many uncertainties and factors to consider, such as being able to identify the reasons for staff absences, to attempt detailed cost calculations[18].

11 In our report *A Safer Place to Work: improving the management of health and safety risks to staff in NHS trusts* we estimate that the direct cost of work-related incidents is £173 million per annum, (excluding staff replacement costs, treatment costs and compensation claims)[7]. Given that violence and aggression account for 40% of incidents reported to us, a crude estimate suggests that the direct cost is likely to be at least £69 million per annum. This takes no account of the human costs, such as physical and/or psychological pain and increased stress levels, which are known to be substantial, nor the impact of violence and aggression on staff confidence and retention.

12 Measures to reduce violence need to be based on sound risk assessment and risk management underpinned by effective strategies and locally developed policies[19]. The Health and Safety Executive identified concerns about the lack of risk assessments in NHS trusts in situations where staff were at risk from violence **(Appendix 4)**. Around 90 per cent of trusts have policies but the content varies, including over 20 different definitions of violence, and staff and other relevant parties are not consistently consulted in drawing them up. There are concerns that some strategies might conflict with staff's legal rights to defend themselves, but the majority of trusts had not subjected their policy to legal review[20].

13 Managing violence and aggression involves a range of action including risk assessment, prevention, timely response, and also learning from incidents[19]. All NHS trusts recognise that some form of training is necessary to help prevent incidents, including induction training aimed at all staff, and dedicated violence-related courses directed at staff particularly at risk. However, there is little evidence of risk assessment of training needs, wide variations exist in the level and types of training provided and in the numbers and types of staff receiving the training, and there is a lack of evidence-based information on successful approaches[20].

14 Three quarters of nursing staff have received induction training and, together with NHS ambulance trust accident and emergency staff, are the most likely group to attend specialist, violence related training courses. In contrast, only half of all doctors have received any induction training and are the least likely to attend other courses, this is particularly so for junior doctors who are often on rotation and face conflicting demands on their time, making attendance difficult. Although *zero tolerance zone* guidance stresses the need for all staff who interact with the public to receive appropriate training, support staff such as receptionists and porters rarely receive adequate training. Overall, 80 per cent of trusts' accident and emergency department managers and sixty-eight per cent of ambulance trust operational managers believe that the level and coverage of violence and aggression training that their staff receive is inadequate.

15 We found a lack of consistency in the way that NHS trusts manage the consequences of violence and aggression, including the support provided to those staff affected. Some trusts provide their staff with fast access to counselling and other support mechanisms while others provide only limited access. A Nursing Times survey of 1,500 nurses in April 2002 showed that, of the 581 who had been assaulted whilst on duty, only 11 per cent were afforded counselling following the incident, and this can be a significant reason why staff choose not to report cases[21]. Departmental guidance issued to trusts in October 2002, emphasised the importance of counselling services being available, but only after an assessment has been made as to its likely benefits as evidence suggests that poor services or those used inappropriately, can do more harm than good[22].

16 There is a balance to be drawn between the amount of security that can be put in place and the operational requirements of NHS trusts and creating a patient-friendly environment[23,24]. Security measures vary across trusts, for example the use of CCTV (92 per cent of trusts), panic alarm systems (85 per cent of trusts) and having security staff (40 per cent of trusts) and or a police presence (20 per cent of trusts). While a number of good practice case examples demonstrate that there

have been some successes in reducing violence and aggression, most of the evidence is anecdotal and there is limited quantifiable evidence on the effectiveness of these measures[24].

17 Research shows that rising activity levels and staff workloads make NHS trusts more susceptible to increased risks[24,25]. In accident and emergency departments, factors such as reducing waiting times and improving the waiting environment, are seen as key to reducing violence and aggression by removing causes of stress to patients and their families. The approaches used to improve the waiting environment vary, for example the use of information screens, refreshment areas and children's play areas, but many trusts identified a problem in making a business case for investment due to a lack of scientific evidence of the effectiveness of these measures[24].

18 Violence and aggression against NHS staff results from a complex combination of personal or situational reasons such as fear, anxiety or frustration, medical or psychological conditions, drugs or alcohol[12], and it is difficult to predict when and what might trigger an incident. Measures that aim to deter people from acts of violence are essential, but while most NHS trusts have promulgated the policy of zero tolerance (4 per cent of trusts have not advertised the campaign), translating theory into practice has proved difficult for some. In particular, while there is no central data on prosecutions, staff surveys show that prosecutions are rare[14,20]. Although all trusts were required to assess the need for a policy on withholding treatment by April 2002[26], we found that 39 per cent of trusts had such a policy and 44 per cent were developing one. This deadline was subsequently extended to 31 October 2002. In practice, most trusts have found it difficult to implement.

19 The NHS cannot tackle this issue alone. They need to work in partnership with the local police and also the Home Office, Crown Prosecution Service, Social Services and the media[19]. The launch of the NHS *zero tolerance zone* campaign is a good example of this partnership working[8] and in September 2000, new sentencing guidelines were issued to ensure that magistrates take into account when sentencing whether the offence occurred in hospital or medical premises and whether the victim was serving the public[27].

20 While 61 per cent of accident and emergency departments and NHS ambulance trusts believe that they have satisfactory or very satisfactory relationships with their local police, staff need a clearer understanding of what, when and how to report incidents to them, and the police and magistrates need to adopt a more consistent approach to dealing with incidents in NHS settings.

21 The Department's 2000 report, *Organisation with a Memory*[28], concluded that most incidents involving patients are systemic and that there are clear lessons to be learned from other industries, for example security and protective services, public transport, educational and welfare and retail outlets. The Department's guidance and good practice examples on the *zero tolerance zone* web site already reflect most of the approaches taken by other sectors, and indeed in many respects may lead the way. Likewise, international research into *Workplace Violence in the Health Sector* concluded that the resource packages provided in the *zero tolerance zone* campaign are "the most comprehensive"[29].

22 From April 2003, the new Counter Fraud and Security Management Service, established as a Special Health Authority in January 2003, will take over responsibility for all policy and operational matters relating to the management of security in the NHS, including leading the work on reducing violence and aggression against NHS staff. Prior to this, responsibility has been with NHS Human Resources Directorate who lead on all staff welfare, health and safety issues under Improving Working Lives. It is essential that any transfer of responsibilities maintains the progress to date of the *zero tolerance zone* campaign and that preventing violence remains an integral part of improving the quality of working life for NHS staff.

Recommendations

a

Improving information on the extent and impact of violence and aggression

23 The Department should:

a) issue further guidance on the need for a consistent approach to identifying and recording incidents and measures for tackling under-reporting, drawing on the experiences of those NHS trusts that have introduced a fair and just reporting culture, together with good practice reporting systems;

b) drawing on the opportunity presented by the new performance monitoring arrangements under *Shifting the Balance of Power*[30], encourage the new Strategic Health Authorities and Workforce Development Confederations, to work with NHS trusts to set priorities and local targets for reducing the impact of violence on staff, based on agreed definitions;

c) encourage the new Commission for Health Audit and Inspection to include questions about staff's experience of violence and aggression, including the support provided, using the planned national surveys;

d) help NHS trusts prioritise actions for reducing incidents, by ensuring that the new NHS Electronic Staff Record System is developed to capture information on reasons for work-related staff sickness absences and turnover, including those related to violence and aggression;

e) work with the NHS Litigation Authority and Health and Safety Executive to support the development of a robust costing methodology for assessing the financial impacts/outcomes of incidents of violence and aggression. Full appreciation of the impacts and costs should help NHS trusts prioritise actions to tackle violence and aggression, and develop sound business cases for investment in counter-measures; and

f) ensure that in transferring lead responsibility for reducing violence and aggression to the new Counter Fraud and Security Management Service, that reducing violence remains part of the strategy for improving the quality of working life in the NHS. It is also important that health and safety managers and staff side representatives are consulted in taking forward any changes.

24 NHS trusts should:

g) review their policies to ensure they support a clear, unambiguous reporting culture in which staff understand the need for, and are confident in, making accurate and timely incident reports and how these reports will be dealt with;

h) review their incident reporting systems and procedures to ensure that the information required is properly defined and that staff are clear about why the data is being collected and how it will be used;

i) use the opportunity presented by the new Electronic Staff Record System to ensure that information on extent and reasons for work-related sickness absence is captured and interventions prioritised accordingly;

j) ensure that staff surveys include questions about the impact of violence and aggression, and the constraints to reporting incidents and feed the results into action plans;

k) ensure exit interviews identify cases where staff leave due to concerns or experience of violence and aggression and feed the results into action plans; and

l) set up systems to monitor the cost of work-related ill health retirements, legal fees incurred and compensation awards due to incidents of violence and aggression and that these are reported to the Trust Board at least once a year.

b

Improving the protection of staff from violent and aggressive incidents

25 The Department should:

m) provide a policy framework to help NHS trusts clarify the legal implications of their policies for violence and aggression;

n) encourage NHS trusts to integrate their strategies for managing violence and aggression into the trust risk management arrangements;

o) build on the research already undertaken to identify the most effective techniques of physical intervention appropriate for responding to incidents that commonly occur in the NHS workplace, including both predictable incidents and ways of responding to unforeseeable circumstances that might require physical interventions, and produce and disseminate guidance;

p) build on and develop the work being carried out in relation to training of staff in NHS Mental Health Trusts so as to achieve a system of accreditation for all violence and aggression training;

q) continue to promulgate good practice examples on the *zero tolerance zone* website, particularly where NHS trusts have demonstrated the positive benefits of changes made to the management of violence and aggression, including changes to security measures and to the physical environment;

r) commission research to identify the extent and reasons why staff fail to report serious incidents to the police, what circumstances enable the police to press charges and why some prosecutions are successful and others fail, so that staff have a clearer understanding of the prosecution process as it applies in the NHS;

s) review the guidance on withholding treatment, to ensure that it is being applied consistently and in all sectors; and

t) share good practice in managing violence and aggression with other public and private sector services and industries that have significant contact with the public and continue to promulgate good practice.

26 NHS trusts should:

u) review their policies on violence and aggression including the withholding of treatment, ensuring that they reflect the views of staff, staff representatives, police and legal advisers;

v) review their approach to risk assessment, ensuring that high risk areas such as emergency services are evaluated regularly, appropriate action taken and staff informed of the extent of the action;

w) take a more strategic approach to induction and other training and development based on an annual training needs analysis for all clinical and support staff;

x) ensure that their strategies for occupational health are pro-active and include measures for dealing with the effects of violence and aggression, including understanding its impact on stress, sickness absence and staff retention and providing counselling and other support to staff while ensuring that there is more formal follow-up by managers;

y) apply central guidance on pursuing prosecutions in a consistent and comprehensive way, within a strategy that includes staff support; and

z) ensure full compliance with the statutory requirement to participate in crime reduction partnerships thereby encouraging the development of cross cutting solutions to reducing violence and aggression which benefit the NHS and wider community.

I WANT TO CARE FOR PATIENTS

LET ME DO MY JOB

PLEASE DON'T MAKE IT HARDER

NHS zero tolerance zone

THE TRUE COST OF HARASSMENT

NHS

Part 1 Background

Violence and aggression against NHS healthcare staff is a serious problem

1.1 The NHS employs more than 1 million people[2]. Violence and aggression not only causes them injury and distress and leads to increased sickness absence and low morale, it stops patients being treated.

1.2 In 2000-2001, there were some 84,000 reported incidents of violence and aggression against NHS staff, an increase of 30 per cent over 1998-1999[11]. The increase has continued in 2001-2002 with 95,501 reported incidents. Although all staff are vulnerable, nurses experience the highest number of incidents and the problem is most prevalent in accident and emergency departments, NHS mental health and ambulance trusts.

1.3 Research confirms that levels of incidents in the NHS are high and rising but that the levels of serious physical assaults may be stabilising:

- In 2000, the Health Service Report in its survey of 45 NHS trusts found that 81 per cent had experienced an increase in the number of violent incidents reported in the year to April 2000, and that on average incidents had risen from 1,200 to 1,400 incidents per 10,000 employees[25].
- In 2001, a United Kingdom Central Council for Nursing and Midwifery report, *The recognition, prevention and therapeutic management of violence in mental health care*, based on responses by 839 staff found that three quarters of nurses had been physically assaulted during their career and most had been subjected to violence on at least six occasions[13].
- In 2002, the Royal College of Nursing published the results of its *Working Well* survey covering a random sample of 6,000 nurses. Fifty-five per cent of respondents were working in NHS hospitals, of which 43 per cent reported that they had been harassed or assaulted by a patient/client or the patient's relatives in the past 12 months, with 32 per cent subjected to physical assault[14].
- UNISON's annual membership survey in the health sector showed a rise in the number of staff reporting incidents of violence from 34 per cent in 2000 to 41 per cent in 2001[31].
- The Health and Safety Executive found that physical assaults to NHS staff were the third greatest cause of accidents that resulted in more than three days absence. While there has been a general increase in injuries from assaults from 1996 onwards, there was a reduction in 1999-2000 which seems to have been repeated in the provisional figures for 2001-2002 **(Appendix 4).**
- Out of 34,000 NHS acute trust staff and 6,544 ambulance trust staff who responded to recent staff surveys, 29 per cent and 50 per cent respectively had personally experienced violence and aggression in the previous 12 months[15].

1.4 Staff working in healthcare are at a higher risk of violence and aggression than people working in most other professions:

- The 2000 British Crime Survey showed that nurses have the second highest risk of assault behind security personnel **(Figure 2)**[3].
- The United States Bureau of Labor statistics showed that, in 1999, the rate of assault on hospital workers was over four times greater than staff in private sector industries[32].
- In Europe a pilot study undertaken in 2000 by the European Agency for Safety and Health at Work found that four per cent of all workers interviewed were exposed to physical violence at work, with the Health and Social Work sector at most risk[33].
- A 2002 report by the World Health Organisation found that workplace violence was a global phenomenon undermining staff retention and the delivery of quality healthcare[34].

2 Data from the British Crime Survey showing occupations with a high risk of violent assaults while working (average risk is 1.2%)

Security and protective services	11.4%
Nurses	5.0%
Care Workers	2.8%
Public Transport	2.8%
Catering/hotel/restaurants	2.6%
Educational and welfare	2.6%
Teachers	1.8%
Retail Sales	1.8%
Other health practitioners (including doctors)	1.4%

Source: Data from the British Crime Survey 2000[3]

NHS employers have a legal duty to identify the risks of violence and aggression and develop appropriate prevention strategies

1.5 NHS trusts have been subject to the full requirements of Health and Safety legislation since they were set up in 1991 **(Appendices 4 and 5)**.

1.6 The *Health and Safety at Work etc Act 1974*[35] places a legal duty upon employers to provide for the health and safety of their employees. This extends to safeguarding those who face a predictable risk of violence. These duties were extended under the *Management of Health and Safety at Work Regulations 1992 (further amended in 1999)*[36] which require employers to assess risks to the health and safety of their employees and implement a comprehensive system of safety management, including providing adequate information and training.

1.7 The Department's Heath and Safety Management Controls Assurance Standard (issued in 2000)[37] specifies that the NHS trust chief executive has overall statutory responsibility for managing health and safety risks and for establishing clear lines of accountability throughout the organisation. Most trusts have a health and safety lead who is responsible for recording, monitoring, reviewing and assessing the root cause of incidents; a human resources director responsible for monitoring sickness absence; and an occupational health manager who provides counselling and other support to help expedite a return to work.

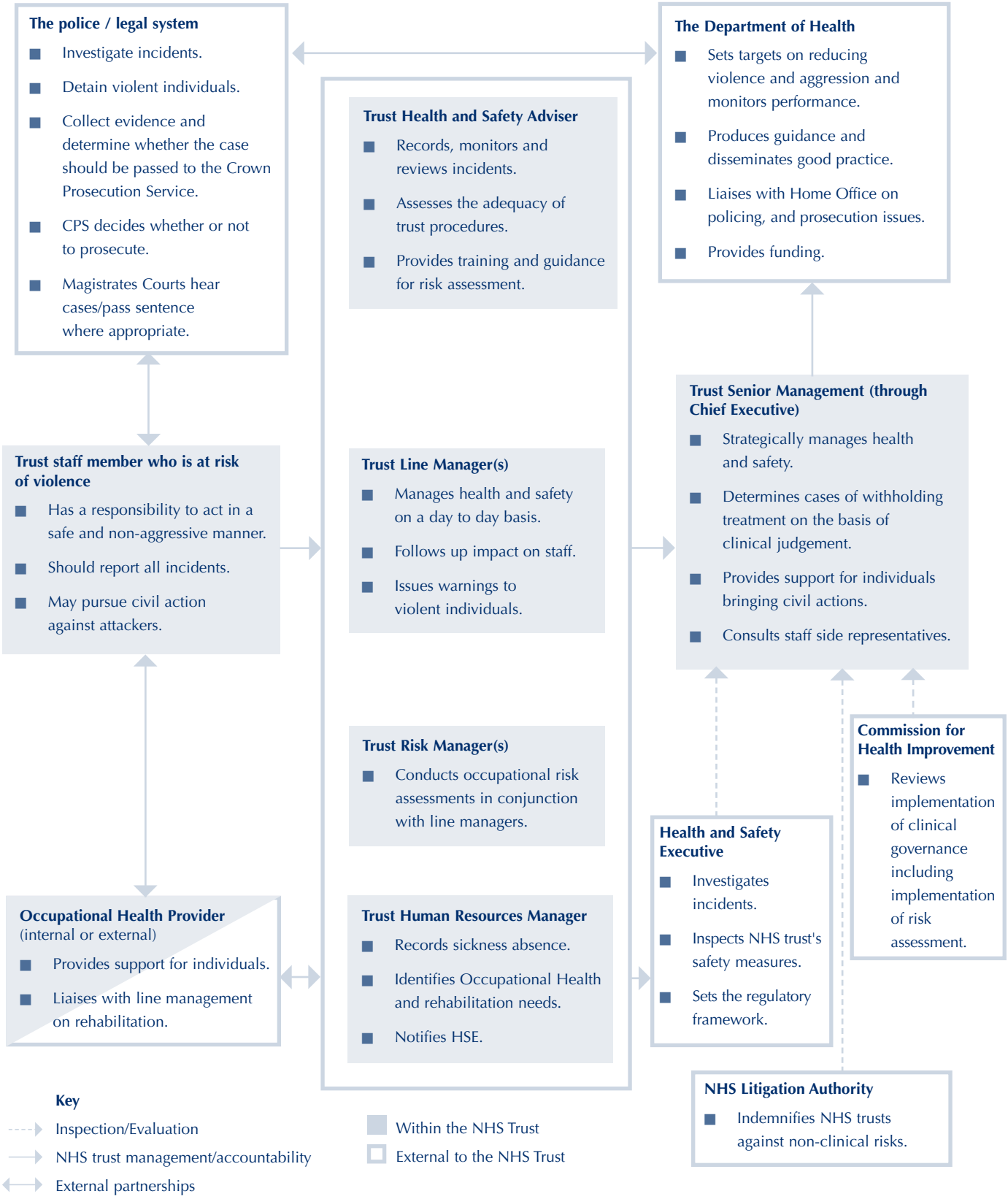
There are a number of external organisations with responsibility for evaluating health and safety in the workplace

1.8 **Figure 3** details the respective roles and responsibilities for the management of violence and aggression in NHS Trusts. Inspection bodies with responsibility for monitoring and reporting on compliance with the statutory health and safety and Controls Assurance requirements in the NHS, include:

- **The Health and Safety Executive:** responsible for the enforcement of the *Health and Safety at Work etc Act 1974*[35]. Inspectors carry out planned inspections of health and safety standards in healthcare premises and can also consider complaints about health and safety and investigate accidents to workers and patients. Since 1996, inspections of NHS trusts have focussed on a number of key risks, one of which is violence. In 2001, the Government launched a 10 year strategy (Revitalising Health and Safety) to reduce the incident rates of accidents, causes of work-related ill-health and number of working days lost. The Health Services were designated as one of the priority areas of action and a strategic programme to target poor performers and address key risks was established. Operational activity has initially focussed on violence and manual handling incidents. **Appendix 4** summarises their findings in relation to violence and aggression as at March 2002.
- **The NHS Litigation Authority:** handles claims and indemnifies NHS bodies in respect of both clinical negligence and non-clinical risks. The Authority also requires NHS trusts to have risk management programmes in place against which they are assessed. Some of the assessments that include non-clinical risk management programmes have yet to be completed and there was no over-view on the management of non-clinical risks available at the time of our investigation.
- **The Commission for Health Improvement:** has statutory powers to help improve the quality of patient care in the NHS by carrying out reviews of clinical governance, including the corporate view of non-clinical risk and confirming that risk assessments are carried out.

1.9 The Police may also be called on to take action in response to reported acts of violence and aggression, and will work in conjunction with the Crown Prosecution Service in determining whether there is sufficient evidence to bring a criminal prosecution.

3 The main responsibilities in relation to violence and aggression



Our 1996 report identified physical assaults on staff as a key issue

1.10 In November 1996 we published our report on *Health and Safety in NHS Acute Hospital Trusts in England* [4]. This examined the number and nature of accidents to patients, visitors and NHS employees; the cost of accidents in acute trusts; and the action hospital managers had taken to address their legal obligations.

1.11 Physical assaults on staff were the fourth most common type of staff incident (14 per cent) after needlestick injuries (16 per cent), slips, trips and falls (16 per cent) and manual handling (15 per cent). The estimate for assaults excluded verbal abuse, which accounted for about 2 per cent of reported incidents. We identified scope for NHS acute trusts to reduce incidents by carrying out a risk assessment of violence from patients, considering the design and layout of the working environment, reviewing staffing arrangements, and introducing focussed education and training programmes to help staff avoid or defuse potentially violent situations.

1.12 The Public Accounts Committee's subsequent report[5] highlighted two surveys conducted by UNISON on violence to NHS staff. These found that less than two thirds of staff were encouraged to report incidents, between 15 and 20 per cent were discouraged from doing so, and a third of staff were unaware of the reporting procedures. The Committee looked to NHS acute trusts to take a stronger lead in encouraging staff to report all accidents promptly.

The scope of our study

1.13 Against this background, we examined the extent to which NHS acute trusts have improved the management and control of health and safety since 1996. Given the significance of this issue in the mental health and ambulance sectors we extended our audit coverage to include these trusts.

- This report focuses on the extent and impact of violence and aggression in NHS acute, mental health and ambulance trusts **(Part 2)**, and the effectiveness of the actions taken by the Department and trusts to improve the protection given to staff **(Part 3)**.
- Our second report, *A Safer Place to Work - improving the management of health and safety risks to staff in NHS trusts,* which will be published in April looks at the management of the wider issues of health and safety risks to staff, including stress and occupational health[7].

1.14 **Appendix 3** summarises our methodology. The full details, including the survey questionnaires, are on our website *www.nao.gov.uk*. The results from our surveys have been shared with the Department. NHS trusts who took part in our survey will be provided with individual feedback reports.

Part 2

The extent and impact of violence and aggression

2.1 This part of our report examines changes in the levels of violence and aggression in NHS acute, mental health and ambulance trusts, action taken to improve the recording of incidents, and the impact on trusts of violence and aggression, including costs. Part 3 examines the action taken to improve the protection given to staff.

Since 1999, the Department has given a high priority to the reduction of incidents of violence and aggression in the NHS

2.2 Our 1996 report and the Committee of Public Accounts hearing highlighted the need to improve the recording of health and safety incidents in the NHS, including incidents of violence and aggression[4,5]. In response the Department issued guidance to NHS trusts to put in place policies and procedures to record, monitor and assess the causes and costs of accidents, sickness absence, ill health retirements and occupational ill health for all health and safety risks[38]. They noted that the risk of violence and aggression should be managed like any other health and safety risk, and that trusts should ensure that incidents were always reported. (**Appendix 1** details progress against the Public Account Committee's conclusions and recommendations.)

2.3 In March 1999, the Department set National Improvement Targets for the NHS[39], including a target to reduce violent incidents by 20 per cent by end 2001-2002, and 30 per cent by end 2003-2004. In order to assess the levels of reported violence, accidents and sickness absence in the NHS the Department carried out a survey during 1999[9]. Our companion report, *A Safer Place to Work - improving the management of health and safety risks to staff in NHS trusts*, examines in detail the issues in relation to accidents and work-related sickness absence and the rest of this report focuses solely on violence and aggression[7].

2.4 The Department's survey identified significant degrees of under-reporting and that employers were using different definitions of violence and aggression, in particular that large numbers of NHS trusts were failing to include incidents of verbal abuse in their reported statistics[9]. They therefore recommended that trusts and health authorities should, by April 2000, have systems in place for recording incidents of violence to staff based on a standard definition of violence (Executive Summary, Page 2).

2.5 NHS trusts and health authorities were also required, by April 2000, to publish strategies for reducing violent incidents to staff, and to work with Regional Offices to agree individual performance improvement targets for 2001-2002. In practice, the NHS reorganisation under *Shifting the Balance of Power* [30], which came into effect from April 2002, meant that this performance monitoring and setting of individual targets was not carried out for 2001-2002.

Most NHS trusts reported an increase in levels of incidents in 2000-2001 and missed the target of reducing incidents by 20 per cent by March 2002

2.6 Under the aegis of the NHS *zero tolerance zone* campaign the Department carried out a further survey in 2001 to establish levels of sickness absence and the number of accidents and violent incidents in 2000-2001[11]. The Department used the information from this survey as the baseline for measuring performance against the *Working Together* National Improvement Targets[9]. We have now collated data at the first target date of 31 March 2002.

4 Incidents of violence and aggression 1998-1999 compared with 2000-2001 and 2001-2002

Type of NHS trust	1998-1999 Reported number of incidents of per 1000 staff per month	2000-2001 Reported number of incidents per 1000 staff per month (baseline)	2001-2002 Reported number of incidents per 1000 staff per month
Acute	3	5	7
Multi-service	9	8	Not applicable (iv)
Ambulance	7	13	12
Community/mental health	14	23	Not applicable (iv)
Mental health/learning disabilities	24	27	35
All NHS trusts	7	10	14
(Total incidents)	**(approx 65,000 incidents)(i)**	**(84,214 incidents)(ii)**	(95,501 incidents)(iii)

NOTES

(i) The figure for 1998-1999 was an extrapolation based on data provided by 364 NHS Trusts.

(ii) The Department surveyed 317 NHS trusts plus, 164 primary care trusts (PCTs), 95 health authorities (HAs) and 11 special health authorities (SHAs). Returns were received from 312 trusts, 28 PCTs, 83 HAs and 5 SHAs (some organisations were unable to supply data due to reconfiguration). Of those that did reply, 8 trusts, 5 PCTs, 69 health authorities and 3 special health authorities had a nil return.

(iii) Based on returns from all 282 NHS Trusts - a small number of trusts were only able to provide partial data due to trust reconfigurations and four trusts were unable to provide any data .

(iv) NHS Multi-service Trust and Community/mental health trust is no longer a designated type of trust as services have been reconfigured into either a mental health trust or PCT (PCTs were not included in our survey).

Source: Department of Health and National Audit Office surveys

2.7 As **Figure 4** shows, the Department's 2000-2001 survey identified 84,214 reported incidents of violence or aggression, an increase of 30 per cent over 1998-1999[11]. We found that the number of reported incidents increased still further to 95,501 at 31 March 2002, a 13 per cent increase compared with the target reduction of 20 per cent. Also, the number of incidents per 1000 staff per month rose from 7 in 1998-99, to 10 in 2000-2001 and 14 in 2001-2002.

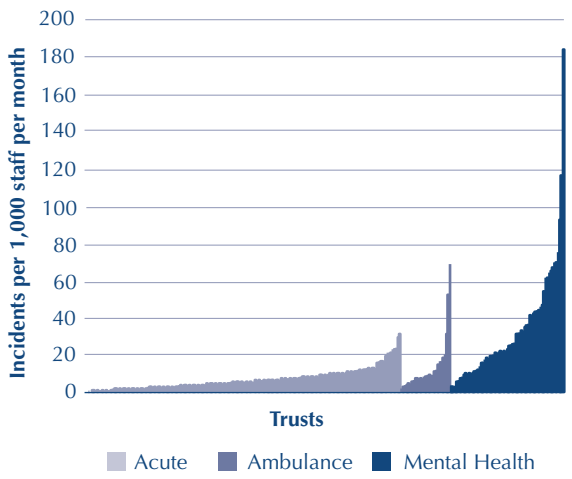
2.8 In the 182 NHS trusts where we are able to make a direct comparison between 2000-2001 and 2001-2002 data, based on incidents reported to us, only a fifth achieved the target reduction of 20 per cent by March 2002, 4 per cent achieved a reduction of 11-20 per cent and 10 per cent a reduction of 0-10 per cent. Sixty-six per cent reported an increase.

2.9 There are wide variations between NHS trusts in the number of incidents per thousand staff per month **(Figure 5)**, and wide variations between trusts in different strategic health authorities, with links between violence and aggression and inner cities and other high crime areas (see Figure 1 in Executive Summary). It is important to stress, however, that there is not necessarily a correlation between high numbers of incidents and failure to manage violence and aggression. Indeed, some of the trusts with high levels of reporting are known by the Department to be good practice trusts but, because of the high profile given to the issue and staff's confidence in the reporting system, have high rates of reporting.

2.10 In line with other research, NHS mental health/learning disability trusts, while showing slight improvements, still have the highest risk (the average number of incidents in 2001-2002 was two and a half times the average for all trusts). This is despite the fact that the levels of tolerance are much higher in mental health settings and they are much less likely to report verbal abuse[13, 40,].

2.11 Our analyses also show that ambulance staff have a higher risk of experiencing a violent or aggressive incident than staff in NHS acute trusts, a problem that is experienced in a number of many other countries[41].

5 Number of reported incidents of violence and aggression per 1,000 staff per month per Trust in 2001-2002



Source: National Audit Office survey

Case example 1

Reduction of violent incidents of actual assault by the Royal Berkshire Ambulance Trust

Situation A small ambulance trust with approximately 190 accident and emergency operational staff, but the incident reporting system showed increasing levels of violence and aggression towards employees.

Action taken Since 1999 the Trust has introduced a number of complementary measures to reduce the risk of violence to its operational staff. These include the encouragement of staff to report all violent and aggressive incidents, the flagging of known dangerous addresses by the control room, procedures for withdrawal from an accident scene at the first threat of violence and partnership working with the Police. The Thames Valley Force deliver training for dealing with violence and aggression and crews either are supported from the outset, when potential violent incidents are attended, or responded to immediately once an ambulance's radio system is activated.

Outcome Although statistically the total number incidents remain stable, these measures have helped reduce the incidents of actual assault by 60 per cent between 2000-2001 and 2001-2002. This has been sustained over the last six months.

	1998-1999	1999-2000	2000-2001	2001-2002	2002-03 (half year)
Violent incident - risk of injury	10	21	32	31	14
Violent incident - assaults	27	23	20	8	5
Total reported incidents	37	44	52	39	19

These findings are supported by the results of staff surveys[16]. Case example 1 shows how one ambulance trust has reduced the numbers of actual physical assaults while the number of reported incidents where there was a risk of injury has remained relatively static.

2.12 Staff in accident and emergency departments also experience a higher incidence of violence and aggression. For those NHS trusts where we have comparable information on the number of reported incidents in accident and emergency departments and the trust as a whole, violence and aggression in accident and emergency account on average, for 43 per cent of all reported incidents.

The increase is due, in part, to increased awareness but under-reporting is still a problem

2.13 Against a background of significant historical under-reporting of violence, the Department's 2000-2001 survey[11] noted that the rise between 1999 and 2001 was likely to reflect increased awareness of the need to report, and that verbal abuse as well as physical assault was being reported.

2.14 Given the complexities involved in interpreting the data, 72 per cent of NHS trust health and safety leads told us that they considered that the number of incidents had increased over the period 1999-2000 to 2001-2002, 13 per cent saw no change and 14 per cent believed that there had been a decrease. Health and safety leads and occupational health managers confirmed that increased awareness coupled with improved training on what constitutes violence and aggression has continued to contribute to a rise in reported incidents. Other reasons cited, were that better reporting systems (12 per cent) encouraged reporting; and that increased workload (11 per cent), an increase in drug and alcohol problems (4 per cent) and the feeling that society in general is more violent (12 per cent) had resulted in an increase in incidents.

2.15 Our survey of accident and emergency managers painted a similar picture. In the 69 per cent of departments who reported an increase in incidents, the most common reasons were the sheer volume of patients and consequent increases in waiting times (48 per cent), increased patient expectations (44 per cent), and an increase in drug and alcohol related incidents (39 per cent). Three accident and emergency managers noted that new pubs and clubs in town had led to a noticeable increase in incidents. Overall, only 7 per cent of accident and emergency departments experienced a decrease.

2.16 Nevertheless, many NHS trusts still believe that staff are less likely to report violence and aggression than any other health and safety incident. For example:

- 90 per cent of accident and emergency managers told us that that there was under-reporting in their department, (the average estimate being 39 per cent under-reporting);
- in staff surveys[15] only 28 per cent of ambulance staff and 18 per cent of acute trust staff who had experienced an incident, actually reported the incident;
- in April 2002, the Royal College of Nursing *Working Well* survey of 6,000 nurses[14] found that 43 per cent of nurses in NHS hospitals had been assaulted or harassed in the last 12 months but around half of them did not report the incident formally;

These examples illustrate some of the more significant types of physical assault, there are many other examples where the staff dealt with the problem and diffused the situation before an actual assault could happen.

NEWS

TRAGEDY AT WORK

A paramedic lost an eye when a brick was thrown through the windscreen of his ambulance. This was not a one off incident as it followed a series of attacks on vehicles, both in Derbyshire and in other parts of the country.

Nurse kicked in face

A female staff nurse was helping dress a female patient who suddenly kicked her in the face breaking a tooth.

NURSE RESIGNED BECAUSE SHE DIDN'T FEEL SAFE!

A staff nurse who was hit by a mental health patient was knocked out and needed stitches. She was off work for 3 months. The patient's observation and care assessment was not reviewed and the patient continued to be nursed on an open ward.

The nurse felt unsafe and was not able to return to post and resigned.

Shocking facts of life in A&E

A male deputy charge nurse was talking to a female patient in A&E. He felt she was becoming hostile so stopped the conversation and walked away. The patient followed and punched him in the face.

FOURTH ATTACK IN TWO WEEKS

A nurse was threatened with a knife by a drunk, violent patient. The nurse had been attempting to reason with the patient but had been unable to calm him down. It was the fourth serious incident at the hospital in a fortnight

Patient's violent outburst

A patient on gastroenterology ward attacked several members of staff and a patient. Three members of staff ended up in casualty

STAFF NURSE ATTACKED

A female staff nurse was treating a male mental health patient in a side room. The doctor arrived and the patient became agitated. After the doctor left, the patient attacked the nurse who sustained a broken nose.

NEWS...

LACK OF SECURITY LEADS TO ASSAULTS

In a hospital where there is no security provided at night, 3 nurses were assaulted on separate occasions in one month in Accident and Emergency

Youths attack security officers

Security officers at a hospital intercepted a group of youths on the hospital site. The youths became aggressive and were joined by others from a nearby estate. Two officers were attacked, kicked and punched. The Trust has since had problems recruiting and retaining security staff.

- the Health and Safety Executive estimates that only 42 per cent of all health and safety accidents that should be reported to them under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR), are reported **(Appendix 4)** - see also *A Safer Place to Work - improving the management of health and safety risks to staff in NHS trusts*[7]; and
- our review of the Commission for Health Improvement's published reports identified concerns about the failure to report verbal abuse and that in general doctors were reluctant to report health and safety incidents of any kind.

2.17 Reasons provided to us for continued under-reporting of violence and aggression, many supported by staff surveys and academic research[13, 29], include:

- different interpretations of what constitutes a reportable incident, particularly verbal abuse. Front line staff and staff in NHS mental health trusts, can become inured to verbal abuse;
- staff perceptions that involvement in a situation would be seen as their failure, and/or their mishandling of the situation and be regarded as professional incompetence;
- some staff are so distressed that they do not want the attention a report would bring;
- staff will only report incidents if they believe action will be taken to address the root cause;
- staff find NHS trusts' reporting forms onerous and time consuming to complete; and
- over two thirds of staff in accident and emergency departments feel that feedback as to what action has been taken in response to their reports is not effective therefore reducing the incentive to report.

NHS trusts have adopted a range of approaches to improve incident reporting

2.18 In 1996[4] we found that few NHS trusts had robust incident reporting systems. The Department therefore recommended that trusts should put in place policies and procedures to investigate, record, monitor, review and assess the causes and costs of accidents by April 2000[6, 38]. They left it to trusts to determine the best reporting system for their local circumstances but provided examples of what might be included in the resource packs issued to trusts as part of the first phase of the *zero tolerance zone* campaign[8].

2.19 We found that four fifths of NHS trusts now record incidents involving staff on the same reporting system used for clinical and non-clinical incidents involving patients. The types of systems used vary with the most common being Safecode (34 per cent) and Datix (28 per cent of trusts). Within trusts, the Commission for Health Improvement has identified inconsistencies in incident reporting systems and a degree of confusion in those cases where staff have to complete different forms for different incidents. Even when a single form is used staff often find that the procedures they need to follow are unclear.

2.20 NHS trusts have taken a number of initiatives to encourage reporting. The most common include having a documented policy that encourages staff to report all incidents; making the reporting form or procedure easier to use; actively promoting the need to report incidents through the use of posters, presentations, workshops, etc; and introducing a telephone "hot-line" reporting system.

2.21 The *zero tolerance zone* web-site, www.nhs.uk/zerotolerance, gives a number of examples of NHS Trusts who have simplified their reporting requirements, leading to improved reporting. We found that 64 per cent of accident and emergency departments have introduced simplified reporting systems aimed, in particular, at encouraging staff to report verbal abuse or harassment. Case example 2 shows the actions taken by one trust where under-reporting was considered a significant issue.

Feedback of results and evidence that action has been taken can improve reporting

2.22 The Royal College of Nursing 2002 survey of 6,000 nurses[14] noted that most cases of serious physical assault were reported, usually through completion of an accident report form (41 per cent) or by reporting the incident to a more senior member of staff (42 per cent). However, in nearly 80 per cent of cases there was no outcome from the action. In 8 per cent of cases a verbal warning was issued by the NHS trust, in 5 per cent care was discontinued and in 5 per cent the incident was reported to the police. In only two per cent of cases was the offender prosecuted. The Royal College concluded that unless trusts could demonstrate appropriate action through feedback to staff then under-reporting would continue to be a problem.

2.23 Virtually all NHS trusts told us that they are taking action to foster a 'just and fair' or 'blame free' culture to encourage reporting of all incidents. Around two thirds are providing training (induction and refresher) on reporting. But feedback remains variable and whilst just over half of all trusts report details to the Trust Board, only 37 per cent provide any feedback to staff.

Case example 2

Guy's and St Thomas' NHS Trust Accident and Emergency Department

Situation The Trust Accident and Emergency Department has experienced a significant increase in the number of reported incidents, particularly physical violence and very serious assault (increased from 182 recorded incidents in 2000-2001 to 245 in 2001-2002, an increase of 35%). These included increases in drug and alcohol related incidents and in the number of patients with mental health problems. The Trust recognises that this may partly be a reporting issue as staff have been encouraged to report all incidents and not to accept violence as an inevitable part of the job. On the other hand, they estimate that under-reporting is still around 75 per cent, particularly for verbal abuse. They consider that public expectation of the service has altered with more people expecting immediate service no matter what the problem and becoming very aggressive on arrival.

Action taken The Trust's new Adverse Incident Policy includes procedures to ensure all incidents are reviewed, more serious ones are investigated thoroughly and where possible action is taken to avoid a re-occurrence. Staff are encouraged to communicate with patients about waiting times and update patients during busy periods when waiting times may increase. CCTV has also been installed throughout the department and is monitored from a central console. A personal alarm system for all staff is also in place. Security guards are present 24 hours a day and have been increased to two at nights and weekends. The walk-in entrance has been moved so that all patients and visitors arriving can be monitored from the security desk and all other entrances have swipe card access. The Trust Security Manager runs training days in managing violence and aggression, which all accident and emergency staff are required to attend. Staff are encouraged to report assaults to the police and-pursue legal action when it is appropriate.

The Trust has a number of policies to assist staff in the management of violence, including the Management of Violent Incidents Policy, the Warning of Violent Patients Procedure and Guidelines on how to Prevent and Manage Violent Incidents.

Outcome The accident and emergency staff feel that the initiatives that have been put in place have demonstrated the Trust's concern for their safety and well-being, and this has raised morale. The improved morale and the knowledge that security is enhanced throughout the department has given them greater self confidence in their ability to deal with difficult situations.

There is still little comparable information on the impact and costs of violence and aggression

2.24 In 1996 we found very little information on the costs to the NHS of health and safety incidents involving staff[4]. Even though the Health and Safety Executive have undertaken some generic work[42], and the Department have reminded NHS trusts in successive pieces of guidance of the importance of assessing costs[6,38] little has changed. And while many studies have highlighted the negative and costly impact that violence and aggression can have on staff and on society as a whole, they have not provided monetary values[12,13,17,18].

2.25 Whilst physical assaults can vary in impact, from minor discomfort, through pain, long term suffering, and even disability or death, there are also the less visible but debilitating effects of anxiety, stress and loss of confidence which can undermine productivity. For example, both the Royal College of Nursing's *Working Well* survey[14] and research by the Institute of Employment Studies 2001 Quality of Working Life survey[43,] found that nurses who had been assaulted or harassed showed poor psychological well-being and were more likely to consider leaving their job within 12 months than nurses who had not been harassed or assaulted.

2.26 While a minor incident may not incur much in the way of direct costs, it can nevertheless result in low morale, a less efficient and effective approach to duties, affect the morale of other staff and require some training or new equipment to avoid a repeat. The more staff are exposed to violence and aggression the greater the impact **(Figure 6)**[17].

6 Consequences of Exposure to violence and aggression

- ▲ burn out, leading to emotional, exhaustion and depersonalisation
- ▲ symptoms of stress ('blue', 'nervous', 'edgy')
- ▲ periods of (certifiable) absences
- ▲ number of cigarettes smoked per day
- ▲ number of units of alcohol consumed per week

- ▼ general health (increase in common illness symptoms)
- ▼ hours of quality sleep per night

Source: Audit of Midlands NHS Community Health Care Trust[17]

2.27 In 2002, the International Labour Organisation commissioned research into *The Costs of Violence/Stress at Work and the Benefits of a Violence/Stress Free Working Environment* from the University of Manchester Institute of Science and Technology[18]. The report, which links violence to stress, is essentially a literature review across all employment sectors and highlights theoretical and methodological problems in costing these issues. The costs used primarily relate to sickness absence, reduced productivity, replacement costs and additional retirement costs. The report makes no attempt to provide detailed cost estimates due to the number of uncertainties and factors that need to be considered. However, based on a number of studies by economists, the report suggests that stress and violence possibly account for 30 per cent of the overall cost of ill health and accidents.

2.28 An alternative approach is to use the annual cost of ill health and accidents calculated in our report, *A Safer Place to Work - improving the management of health and safety risks to staff in NHS Trusts,* in which we estimate that the direct cost of work-related incidents is £173 million[7]. Given that violence and aggression account for 40 per cent of all incidents reported to us, a crude estimate suggests that the direct financial cost of violence is likely to be at least £69 million. This takes no account of the additional financial cost of temporary staff; fees for legal action; counselling if required; and the costs of training for replacement staff should the member of staff leave the profession; or the human costs of physical and/or psychological pain, increased stress levels, loss of experienced staff and loss of confidence.

Part 3

Protecting staff from violence and aggression

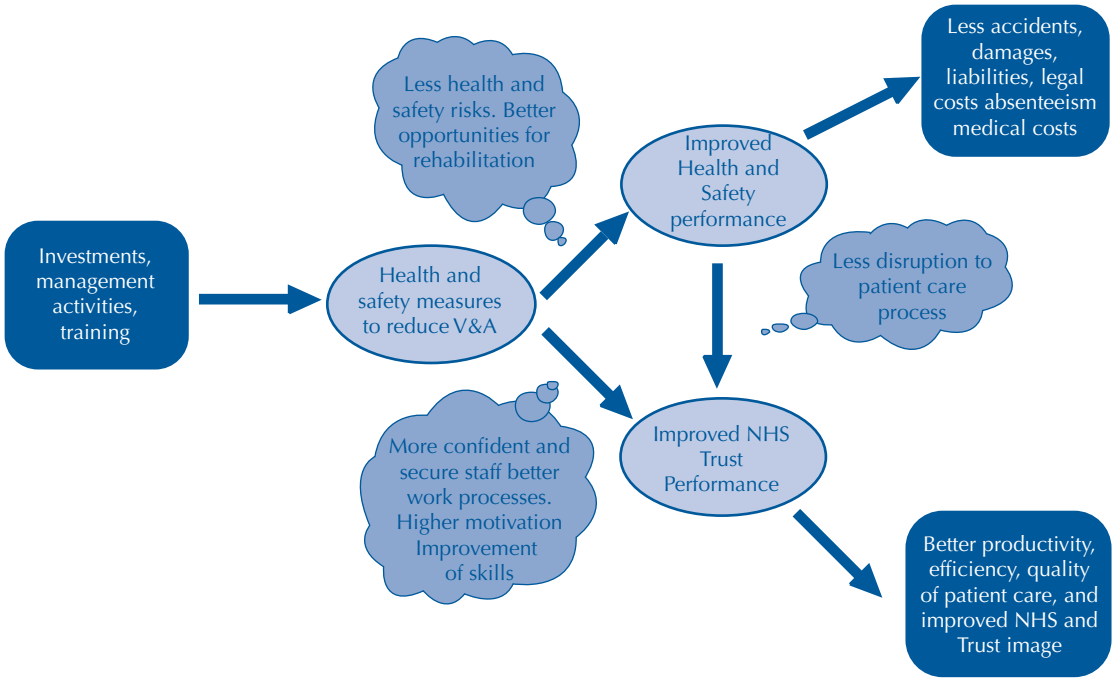
3.1 NHS trusts have a legal duty to take all reasonable steps to protect staff from violence and aggression[35,36]. **Figure 8** shows that taking effective action can also improve the overall well being, productivity and retention of staff, and reduce costs. In this part we examine the specific initiatives taken by trusts to address the problem of violence and aggression.

In response to our 1996 report, the Department identified steps that NHS trusts should take to minimise the risk of violence and aggression

3.2 Following our 1996 report[4], the Department issued guidance on the need for effective management of health and safety and for NHS Trust Boards to give serious consideration to our recommendations[38]. The Department identified specific steps that needed to be taken to minimise violence and aggression, including the need for:

- risk assessments;
- an action plan to identify, analyse and rectify problems;
- reporting of all incidents of violence and aggression;
- training to educate staff on how to avoid or defuse potentially violent situations and how to respond appropriately to incidents of violence;
- support and counselling for all staff who were subjected to violence;

8 Benefits to NHS trusts of preventing violence and aggression



Source: FACTS: European Agency for Safety and Health at Work[39]

- effective technology and procedures so that staff can summon assistance if required (eg alarm systems); and
- care plans that indicate whether specific precautions are required for specific patients.

3.3 Of the range of guidance and action taken, the *zero tolerance zone* campaign[8, 19] was an important milestone as it made it explicit that the NHS would no longer tolerate violence and aggression against its staff, and detailed specific actions for NHS trusts. Subsequent guidance developed these requirements for action still further **(Appendix 2)**.

3.4 In the following paragraphs, we measure progress against eight key actions that we have identified NHS trusts are expected to take to improve prevention of violence and aggression:

a) risks assessments should be undertaken and prevention and risk reduction strategies and action plans developed (including care plans for specific patients) (paragraphs 3.5-3.9);

b) local policies should be developed in consultation with staff (paragraph 3.10-3.14);

c) training should be given to staff (paragraphs 3.15-3.23);

d) support and counselling should be provided for staff subjected to incidents (paragraphs 3.24-3.27);

e) technology and other security measures should be used to protect staff (paragraphs 3.28 3.33);

f) the environment should be assessed to reduce potential triggers (paragraphs 3.34-3.37)

g) withholding treatment is an option (paragraphs 3.38-3.41); and

h) trusts should work closely with the police to formulate local crime and disorder strategies (paragraphs 3.42-3.50).

9 A suggested approach to risk assessment.

The amount of effort needed to control risks is different for different situations. While there is no hard and fast approach the basic principles are:

- identify that risks exist, ideally through talking to staff who work in the system;
- assess and evaluate the identified risks using a simple ranking to develop a risk matrix;
- develop solutions to remove, minimise or reduce the risk, this can be achieved by reducing the frequency (for example using CCTV) or reducing the consequence (eg storing drugs in secure environment). Most solutions will have a cost associated with them and a cost benefit analysis will help get the best out of any improvements;
- implement the solutions and ensure that all staff are aware of the measures being taken, ideally instilling a sense of ownership of the change; and
- regular monitoring is necessary for continuous improvement - risk assessment and management must be an iterative process.

Source: Effective management of Security in A&E by AEA Technology based on work undertaken on the Hartlepool and East Durham Trust, the Leeds Teaching Hospitals NHS Trust and the Royal County and St Luke's Hospital NHS Trust[24].

(a) Over two thirds of NHS trusts use risk assessment to help identify risk reduction strategies and develop action plans but the quality varies

3.5 In response to our 1996 report[4] the Department recommended that NHS trusts should evaluate the health and safety risks to staff[6]. They told the Committee of Public Accounts that they planned to develop a health and safety risk management tool, in conjunction with NHS Estates, to help trusts improve their management of health and safety risks. In the event this tool was not developed. However, in May 1997, NHS Estates published guidance on the *Effective Management of Security in A&E*. This included guidance on risk assessment **(Figure 9)**[23].

3.6 In 1998, the NHS Executive and the Royal College of Nursing published *Safer Working in the Community: a guide for NHS managers and staff on reducing the risks of violence and aggression*[45]. The report emphasises the pivotal role of collecting evidence from a variety of sources to allow the reliable identification of hazardous situations and at-risk groups. Further, that the identification and analysis of work-related violence, the assessment of the associated risk, and the evaluation of any interventions can be built into an on-going system of monitoring.

3.7 The Health and Safety Executive explicitly required NHS trusts to use risk assessments under its *Management of Health and Safety at Work Regulations 1992*. This requirement was re-enforced further by its 1999 amendment[36]. The Executive subsequently published *Violence and aggression to staff in health services: Guidance on Detailed Assessment and Management*[46]. The importance of risk assessments in preventing violence against staff is also emphasised in guidance issued as part of the *zero tolerance zone* campaign[20].

3.8 In 2001, the survey by Bleetman and Boatman in *Training in conflict resolution skills and the management of aggression and violence in non-mental health settings: An overview of current position and future requirements*[20] found that two thirds of NHS non-mental health and ambulance trusts (66 out of 96 respondents) used a formal risk assessment in relation to violence and aggression. The Health and Safety Executive's 2000-2001 report on their findings from inspection visits to trusts, also identified concerns about the lack of risk assessments in situations where staff were at risk from violence **(Appendix 4)**.

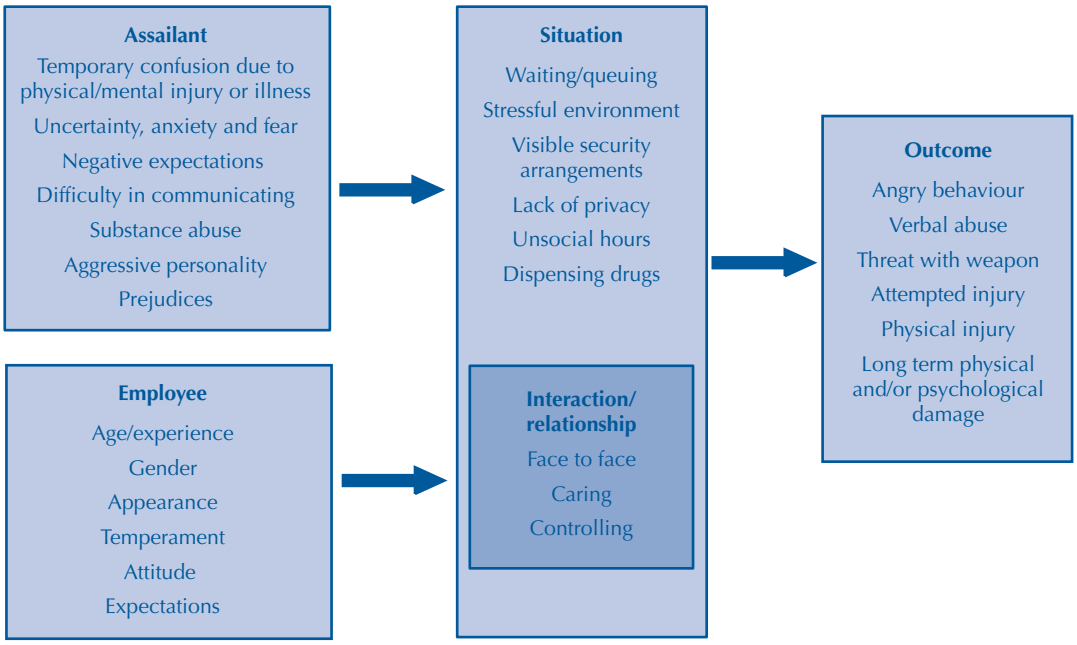
3.9 The NHS *zero tolerance zone* campaign website provides a number of examples of good practice for undertaking risk assessment (www.nhs.uk/zerotolerance/mental/risk.htm and www.nhs.uk/zerotolerance/trusts/risk.htm). The guidance notes that risk assessments need to be part of an ongoing and dynamic process reflecting changing patterns and needs, carried out by appropriately trained staff gathering information from a number of sources at organisational and employee level. However, a number of mental health chief executives and around a fifth of NHS trusts who replied to our survey felt that staff were inadequately trained in undertaking risk assessments in relation to violence and aggression. **Figure 10** provides an overview of the factors that might be considered in undertaking such risk assessments.

(b) Most NHS trusts have developed local policies, in consultation with their staff but definitions used still vary and there are concerns about some legal aspects

3.10 Departmental guidance is that NHS managers can secure the confidence of their staff and demonstrate their support by issuing a policy document addressing safe working conditions, and that they should involve staff, staff representatives and legal advisors in this process[19]. We found that 86 per cent of NHS trusts had a policy on managing violence and aggression and most of the remainder were in the process of developing a new policy following re-organisation.

3.11 The Bleetman and Boatman survey in June 2001 found that 90 per cent of NHS trusts had a policy and that of these, 92 per cent of non-mental health trusts and 78 per cent of the ambulance trusts had consulted their staff in formulating it. Around two fifths had consulted external agencies. However, over 20 different definitions of violence and aggression appeared in the documents[20].

10 An overview of factors that might be considered in a risk assessment of violence and aggression



Source: National Audit Office literature review

Case Example 3

Police advice on some of the questions raised in our survey

- You can restrain persons under common law to protect them, you and others if the threat is perceived to be that great - for example physical or a drug restraint;
- If the patient is deemed not to understand their actions they can be restrained under common law pending detention under the mental health act;
- If they are simply inherently violent individuals - then you can call the police - if there is a perception that imminent violence is about to occur against a person, then they can be restrained under common law pending the arrival of the police;
- You can't forcefully search a person attending hospital but a search can be made a condition of entry (similar to some night-clubs or at airports);
- People can only be transferred against their will if they are under arrest or detained under the mental health act.

Source: Inspector (retired) Peter Boatman QPM Northamptonshire Police

3.12 Only a third of NHS non-mental health trusts and a quarter of ambulance trusts had subjected their policies to legal review[20]. Many trusts appeared to be unaware of the legal implications of some of their policies and told us they would like more detailed guidance in order to avoid having to re-invent the wheel and reduce the cost of seeking legal advice. Case example 3 details police advice to some of the questions on control and restraint noted in our survey.

3.13 Our survey also identified concerns that staff who operated reasonably and lawfully, for example in self defence, but outside the NHS trust policy, could be subjected to disciplinary proceedings.

3.14 The NHS in Scotland has recently developed central NHS guidelines on managing health at work[47]. These cover protecting staff against violence and aggression at work, and include a model policy, which clarifies aims, objectives and responsibilities, the legal issues and a sample checklist for assessing risks. While much of the material in the Scottish guidelines reflects guidance that has been issued by the Department or is detailed on the *zero tolerance zone* website, there is some merit in bringing these disparate pieces of information together in one authoritative and accessible document.

(c) All NHS trusts offer some form of violence and aggression training but there is little evidence based information on its effectiveness

3.15 Departmental guidance highlights the importance of staff knowing how to recognise and respond to potential and actual threats and recommends that NHS trusts should determine training needs by assessing the risks faced by different types of staff. Such training should be "up-to-date, relevant, purposeful, backed by expert guidance and include feedback"[20].

3.16 We found that NHS trusts offer a wide variety of courses, but the patterns and types and the extent to which they are viewed as compulsory or voluntary varies **(Figure 11)**. Syllabi also vary widely. Overall, given that staff face high risks of violence and abuse in mental health and ambulance trusts, our survey raised concerns about the number of trusts who fail to make training in situation risk assessment and customer care compulsory.

3.17 The picture we found is confirmed by research commissioned by the Department (Case example 4) which found "no clear direction or evidence base on which staff training needs are assessed. Training programmes were largely 'off the shelf' and the syllabi were based more on the experience and preference of the trainers than a rational analysis of training needs"[20]. At the same time we also found that some NHS trusts have adopted bespoke training courses which they believe have led to improvements in prevention (Case example 5).

3.18 As regards attendance on training courses, we found that nurses are much more likely to receive induction and other violence and aggression training than doctors. Around three-quarters of NHS trusts provide induction training in violence and aggression to nurses and allied health professionals, ancillary and management staff, compared with 54 per cent to doctors.

3.19 Although accident and emergency departments are in the front line, thereby increasing the need to ensure that staff are trained appropriately, our survey confirmed that doctors, ancillary and support staff receive low levels of training **(Figure 12)**. Likewise in two-thirds of NHS ambulance trusts most of their accident and emergency operational staff have received situation risk assessment training but in only 38 per cent of the trusts do most patient transfer staff receive this training.

3.20 One of the main reasons given for low levels of training by doctors is that they, and particularly junior doctors, have significant clinical training commitments, work on 6-monthly rotations and have high workloads. The new medical school training programmes are starting to address this by including customer care and other violence and aggression training in their curricula, but there is still a need for local induction training.

Case example 4

An overview of the current provision and future requirements of training in conflict resolution skills and the management of aggression and violence

Situation In 2001, the Department commissioned a research study to assess the training needs of NHS staff working in non-mental health settings in relation to recognition, prevention and management of violence and aggression and conflict resolution.

Action The study surveyed 305 acute, community and mixed trusts as well as 30 ambulance trusts. Questionnaires were also sent to a broad range of external organisations including police forces, prisons, transport companies, law courts, security companies, retail organisations, motoring organisations, football clubs and union bodies. A total of 40 personal safety-training organisations also received questionnaires. A further seven contacted the study independently. Around 30 per cent of acute, community and mixed and ambulance trusts responded. Eighteen training organisations completed questionnaires (45%), while seven sent promotional material only. The response rate of the other organisations was 13%.

Material and information from conferences, training manuals, relevant legislation and law, published professional and ethical guidelines relating to the use of force and physical restraint and internet-based research provided further sources of evidence.

Key Findings

1. The *zero tolerance zone* initiative has increased awareness of the dangers of violence and aggression and helped trusts implement plans to improve staff protection.
2. Training boosts staff confidence irrespective of course effectiveness.
3. Simple, police-derived, reflexive skills appear to be the most effective of any physical training approaches.
4. Most training programmes are trainer-led with little attention paid to staff needs or abilities.
5. Few trusts collect data on the safety, effectiveness or relevance of their non-physical and physical training programmes.
6. Most training organisations claimed that their non-physical and physical conflict management programmes had been subject to legal, medical or tactical reviews. However, there was little evidence to support this.
7. Most trusts could not demonstrate the effect of any staff training on the overall threat of aggression and violence, or its effect on the reduction of risk to staff, subjects and the organisation itself.

Conclusions and recommendations

- A common NHS approach to conflict resolution is needed to help trusts in formulating lawful and reasonable policies and adopting a common approach to managing the threat of violence and aggression and protecting staff and patients.
- Incident reporting forms should be amended so that sufficient and accurate data is collected on the specific nature of threats and the effectiveness of any methods used to deal with them. This information can then inform future staff safety training requirements.
- Trusts need to work closely with training providers to ensure that courses are tailored to their specific needs and staff abilities.

Extract from report "Training in conflict resolution skills and the management of aggression and violence in non-mental health settings: An overview of current provision and future requirements" by Anthony Bleetman PhD FRCSEd FFAEM DipIMC RCSEd, Consultant in Accident and Emergency Medicine, Birmingham Heartlands Hospital and Inspector(retired)Peter Boatman QPD Northamptonshire Police[20].

Case example 5

A partnership approach to violence and aggression training by the Surrey police working with five Surrey NHS Hospital Trusts

Problem Five Surrey Hospital Trusts were experiencing between 75% and 150% rise in the levels in reported incidents of violence and aggression. Whilst this was partly the result of increased staff awareness and policies to encourage reporting, there was a growing concern about serious incidents and the effects of threatening behaviour on frontline staff.

Solution In partnership with the Surrey Police, the Trusts set up a project to reduce violent and threatening behaviour towards hospital staff. Two constables were seconded full time for 2 years to work with the Trusts. A Steering Group, which included 1 member from each Trust, was set up to oversee the project. A key component was Surrey Police's one day course, funded by the Home Office, which started in February 2001. Five hundred staff from each Trust from various areas of work, e.g. Midwifery, Security, Community, Geriatrics, Accident and Emergency and Portering attended workshops in the classroom on how to identify conflict; typical physical responses; de-escalation techniques and what staff can do within the law. Role-play and feedback were used and the staff were taught very basic break away techniques. At the same time the Police issued Trusts with a Home Office "Fear of Crime" questionnaire which will be evaluated against a second questionnaire at the end of the project to assess its impact.

Six candidates from each Trust were trained as trainers for the course and these staff were accredited by Surrey Police to deliver the required training to the rest of the Trusts' workforces for 12 months. All staff were required to attend refresher training after one year.

Outcome Trusts have reviewed and revised existing policies and implemented new strategies. Onus is placed on managers to ensure staff awareness. Ashford and St Peters' Hospital introduced regular reporting to the Board with an action plan for violent incidents. Frimley Park Hospital monitors incidents and the security manager regularly liaises with police.

Trainers meet to exchange ideas and good practice. Trusts have also improved security through restricting access to certain departments and extending CCTV coverage and counselling and debriefing support has been made available. Quarterly reports on how the project is progressing are provided to all participants matching police incident and crime data and information from the Crown Prosecution Service and data from the five Trusts on the number of incidents and these are subjected to independent review by a Team from Royal Holloway, University of London.

Source: National Audit Office survey

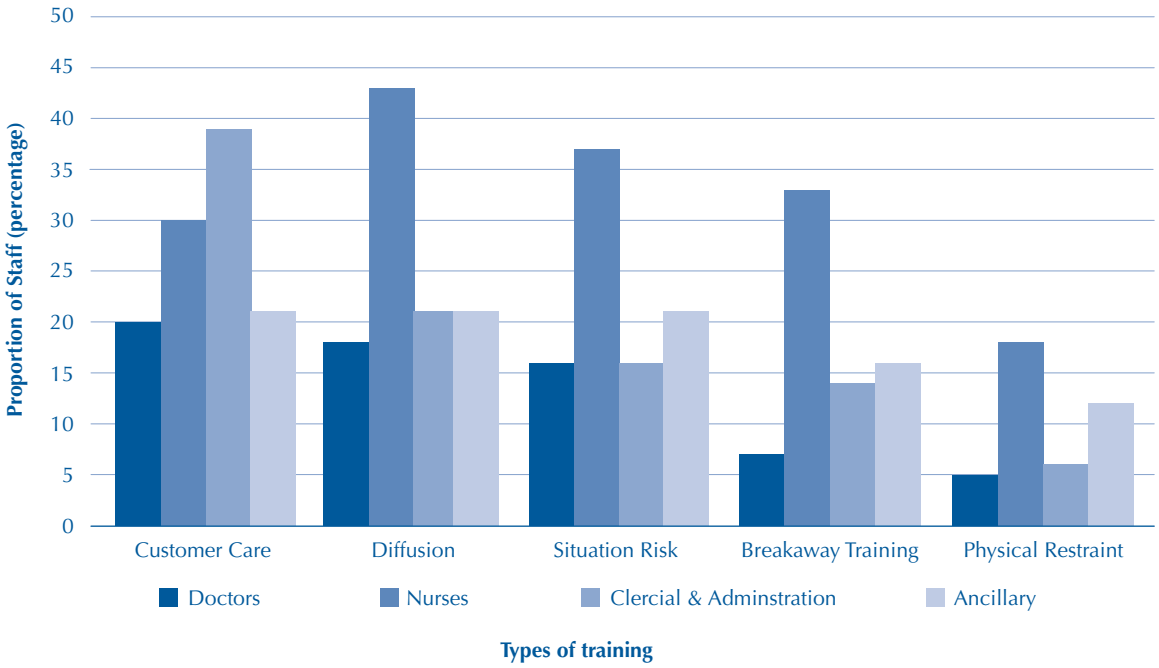
11 Types of violence and aggression training and the extent of compulsion

Types of Training	Type of Trust	Compulsory
Situation Risk Assessment - to assess the risk of violence presented by individual patients, where possible taking into account their demographic or personal background, clinical variables and situational factors. Risk assessments of the working environment are covered.	Acute Mental Health Ambulance	36% **50%** **87%**
Customer Care - to improve staff handling of face to face contact with patients, helping them to identify the needs of patients and their families in order to provide better support for them, thereby reducing potentially tense or volatile situations.	Acute Mental Health Ambulance	36% 36% 45%
Diffusion - a combination of verbal and non-verbal interactions, which help staff reduce the threat of violence, including the patient's anger and return them to a more calm state of mind.	Acute Mental Health Ambulance	31% **70%** **81%**
Breakaway - teaches staff techniques to enable them to break free from holds or a room/location, such as tight corners.	Acute Mental Health Ambulance	32% **79%** 42%
Physical Restraint - Staff are trained to restrain violent patients using restraint techniques and devices	Acute Mental Health Ambulance	28% **73%** 16%

Source National Audit Office survey

3.21 Sixty-eight per cent of NHS ambulance trusts and 80 per cent of accident and emergency department managers cited constraints such as finance, work pressures, staff turnover and the lack of sufficient available courses as reasons for low levels of attendance. Reports from the Commission for Health Improvement confirm this. Of the eight inspection visits to ambulance trusts (reports published by 1 November 2002), two directly referred to service pressures inhibiting the provision and delivery of adequate training for ambulance service staff. Likewise 25 out of 111 published reports on the acute sector specifically referred to the difficulties staff encountered, due to pressure of work, in getting released from their duties to attend training courses.

12 The proportion of staff in the different staff groups within accident and emergency departments who are receiving violence and aggression training



Source: NAO Survey of NHS Trust Accident & Emergency Managers

Case example 6

Portsmouth Hospitals NHS Trust Accident and Emergency Department

Situation Managers were concerned that staff were accepting aggression as part of the job. Staff were being subjected to an increased amount of physical violence and daily verbal abuse. The Department, whilst recognising that the patients attending accident and emergency are likely to be anxious, found the perpetrators were often relatives or friends. It was also noted that incidents were largely alcohol and drug related and occurred at closing time and after sports fixtures had ended.

Action Taken A risk assessment identified that incidents were occurring because:

- the sheer volume of patients in accident and emergency was causing frustration and hostility;
- those with minor injuries could wait a long time in uncomfortable and overcrowded waiting areas; and
- staff were not properly equipped to deal with verbal abuse and potential physical violence.

After considering the risks a programme of action was undertaken

1. New security systems were used, e.g. deploying a security guard on night shifts and installing CCTV in the Department's main areas, card controlled access to higher risk areas, panic buttons and strategically placed intercoms for staff to summon help quickly. Staff working away from the main area were provided with emergency personal alarms.
2. The Department was redesigned to reduce blind spots and waiting areas were made larger and more comfortable. Separate rooms were provided for children.
3. Training sessions on avoiding confrontation; defusing situations; recognising potential aggressors; reasonable force and the law; and, where appropriate, control and restraint techniques were introduced.
4. Staff have been encouraged to report every incident, including verbal abuse, and if a person is aggressive they receive a warning and are asked to stop. If they persist, they are asked to leave and, if necessary, the police are called and asked to remove them.
5. De-briefing sessions have been introduced at the end of each shift. This allows staff to talk about how the shift has gone; review any incidents, which might have taken place, and to consider any lessons learnt.

Outcome Staff morale has increased as they have seen the greater level of support and involvement by senior management

Source: National Audit Office survey

3.22 As regards delivery of courses, we found a wide variety of circumstances, and a growing number of training organisations providing violence and aggression training with no system of accreditation or guidance on what is effective. While 85 per cent of NHS trusts provide some training in breakaway, physical control and restraint techniques, there is very limited research into the safety and effectiveness of these methods in health care settings. Most expert advice considers that such training should only be given to staff in high-risk situations, informed by robust risk assessments to ensure that it is appropriate for their circumstances[20].

3.23 The Department has recently provided support to the British Institute of Learning Disabilities (BILD) for the development of its Physical Interventions Accreditation Scheme with a view to promoting this in NHS mental health and learning disability trusts. The scheme accredits appropriate organisations that provide training and instruction in the management of violence and aggression to staff working with children and adults who are described as having learning disabilities/difficulties; autistic spectrum disorders; and emotional and behavioral difficulties. In February 2003, BILD published its first directory of training organisations accredited under this scheme.

(d) Counselling and other support should be available to staff who have experienced an incident but provision is poor

3.24 Departmental guidance identifies the need for comprehensive occupational health services to reduce the incidence of work-related illness and injury and ensure that staff are able to achieve their full capabilities at work. We examine progress against this in our report on *A Safer Place to Work - improving the management of health and safety risks to staff in NHS trusts*[7].

3.25 Departmental guidance issued to NHS trusts in 2002, on dealing with physical and verbal harassment by NHS service users, emphasises the importance of counselling services being available to staff who report an incident of harassment in the workplace. However, the guidance also stresses that counselling should only be offered after an assessment has been made as to its likely benefits, as evidence suggests that poor services or those used inappropriately can do more harm than good[19]. This can also apply to victims of violence.

3.26 As regards violence and abuse, however, a Nursing Times survey of 1,500 nurses in April 2002 found that 581 (40 per cent) had been physically assaulted in the previous three years, but only 116 (20 per cent) were offered any counselling[21].

3.27 While occupational health services are available to all staff during weekday office hours, we found that the provision of support following violence and aggression was not a priority area for most occupational health services. For the 72 NHS trusts (27 per cent) that have a long term occupational health strategy and the 134 trusts (50 per cent) that have a documented annual programme, the key priorities were moving and handling and stress. Only 20 trusts (15 per cent) included measures to deal with the effects of violence and aggression in their key objectives.

(e) NHS trusts employ a range of different technologies and security measures to improve staff safety but with varying degrees of effectiveness

3.28 NHS trusts have taken a range of measures to improve staff safety, by using new technology and introducing specific security measures **(Figure 13)**.

3.29 Case example 6 illustrates how the Portsmouth Hospitals NHS Trust Accident and Emergency Department used a number of these measures to tackle this issue.

3.30 Visible technology and security measures may not always be appropriate and case example 7 demonstrates the approach taken by South Birmingham Mental Health Trust.

3.31 In addition to NHS trust investment, the Department, under the Improving Working Lives Initiative, part of the Human Resources Performance Framework[48], has set aside £1.5 million for investment in new initiatives over three years, to be matched by £1.5 million from trust funds. In 2001-2002, the first year of operation, the Department received bids of over £4.9 million, and following analysis of the bids by the Regional Offices, some £0.8 million of central funding was used to support 173 local measures to address violence and aggression, including:

- fitting central locking systems to 33 ambulance trust vehicles;
- purchasing personal alarms for staff;
- commissioning personal safety training for staff;
- installing/upgrading CCTV cameras at inner-city clinics;
- installing swipe card access systems; and
- introducing a voice logging protection system for community staff.

13 Examples of the types of investment in security that NHS trusts have made which were provided to us as part of our survey

- Birmingham Heartlands and Solihull Hospitals NHS Trust - received a grant for a new CCTV security system under the Home Office's Crime Reduction Programme. This involved purchasing 29 new cameras and replacing or re-siting existing ones, located in external car parks and the two Accident and Emergency Departments. The new system produces clearer digital images of sufficient quality for use as evidence in a court case. The police will monitor the cameras to ensure a fast response. **Cost - £396,000**
- Poole Hospitals NHS Trust - having identified security as an issue through the adverse incidents reporting system, the Trust introduced regular meetings with the police and installed CCTV systems, together with 24 hour patrols and surveillance. **Cost - £150,000 capital, £200,000 revenue**
- Royal Berkshire and Battle Hospitals NHS Trust - after staff consultation and risk forum meetings, the Trust decided to introduce a 24 hour security service at a cost of around **£500,000** per annum. Safety method statements also required the improvement of personal protective equipment. **Cost - £5,000**
- Peterborough Hospitals NHS Trust - after a review of incidents and a request from staff, 10 one day training courses run by Cambridgeshire Police to learn how to deal with difficult clients and diffuse aggressive behaviour were organised. These were aimed at front line staff, accident and emergency staff, porters, receptionists, security staff and patient liaison officers. **Cost -£5,000**
- The Royal Wolverhampton Hospitals NHS Trust - introduced personal protection training for handling aggressive or abusive patients for nurses, porters, technicians, catering assistants and other staff. They also provided a security package encompassing identity cards, better external lighting and more CCTV for the car parks. A one month pilot with two police officers patrolling between 12 midnight and 4am was undertaken. **Cost - £100,000**
- The Pennine Acute Hospitals NHS Trust - the Health and Safety manager and the Joint Negotiating Consultative Committee at the Rochdale site identified a need for access control, including car park security barriers. **Cost - £105,000**
- South Tees Hospitals NHS Trust -a series of incidents made security a priority for the Trust and Rapid Response Teams were introduced in order to improve protection of staff, patients and visitors. The Trust also purchased stab vests for the security officers. **Cost - £130,000**.
- Northern Lincolnshire and Goole Hospitals NHS Trust - personal protective clothing was identified as an issue and a review commissioned. **Cost - £10,000**
- Devon Partnership NHS Trust - having monitored incident reports the Trust identified a need for, and installed, a staff alarm system and CCTV systems. **Cost - £175,000**
- Bedford Hospitals NHS Trust - the Trust's risk assessment on security prioritised the need for external night patrols, a new digital CCTV system for the car parks and the installation of CCTV within the hospital. A new "Hospitalwatch" book has also recently been issued to all staff members and security is a subject on the induction course. A swipe card access system is being introduced to sensitive areas such as medical records, pharmacy and theatres with a view to extending it over the whole Trust. **Cost - £110,000**
- Mid Staffordshire General Hospitals NHS Trust - after a major review of security, an in-house portering team undertake security duties and the Trust has now appointed a full-time security manager. CCTV and access control systems are being continually improved. **Cost - £50,000, £100,000 per annum** respectively.
- South Tyneside Health Care NHS Trust - risk assessment by the full time security co-ordinator resulted in an access control system and CCTV being installed. **Cost - £160,000**
- Dorset Health Care NHS Trust - a review of incident reporting resulted in the purchase of a panic alarm system. **Cost - £50,000**
- North East London Mental Health NHS Trust - after staff and managers suggestions, personal safety alarms and CCTV were introduced. **Cost - £50,000**
- Oxfordshire Mental Healthcare NHS Trust - the Director of Nursing identified that all patient areas require staff alarm systems. **Cost - £100,000**
- South London and Maudsley NHS Trust - staff surveys identified the need for improved site security. **Cost - £50,000**
- Lancashire Ambulance Service NHS Trust - staff requested security fencing after episodes of vandalism and intimidation. **Cost - £5,000**

Source: National Audit Office survey of NHS trusts

3.32 In addition, around 76 of the 266 schemes funded under the Department's £150 million Accident and Emergency Modernisation programme[49], have been used to bring about improvements in security for staff and patients, many involving the installation of CCTV facilities and equipping nursing staff with personal alarm systems. Furthermore, many of the more general modernisation schemes, such as the introduction of assessment and observation wards, improved resuscitation facilities and designated areas for children, are also intended to benefit hospital staff by creating an environment that is likely to reduce violence and aggression.

3.33 As part of our survey of accident and emergency departments we obtained examples from NHS trusts of measures, including new technology, that have been used to improve security (**Figure 14** and case example 8). Despite this, over 50 per cent of accident and emergency managers told us that the security arrangements in their department were unsatisfactory. Among the weaknesses highlighted were insufficient and poorly trained security staff and the need for a permanent security presence based in the department.

Case example 7

South Birmingham Mental Health NHS Trust

Situation

The design of some of the Trust's three main in-patient areas presents risks of violence and aggression to staff due to stair wells, blind corners and a general lack of space. The nature of the client group served by the Trust means that they can be more prone to unpredictability, and pressure for beds means that increasingly, those patients who are admitted are more acutely ill.

Two years ago the Risk Management team were aware that local good practice was not replicated across all the sites of the Trust, and there was a general lack of agreed policies and procedures on violence and safety issues. Incidents of physical assault were likely to be reported, but many staff accepted threatening and intimidating behaviour as part of their job and it was largely unreported. Staff were also having problems accessing sufficient training.

Action taken

Alterations to the buildings' design were difficult and high profile security measures were felt to be inappropriate for a service of this nature. At the Queen Elizabeth Psychiatric Hospital, a female police officer who is well known to staff and the patients visits the hospital regularly as part of her beat. This is seen to be very helpful. In addition, many changes were made to reduce risks of violence and aggression in as unobtrusive a way as possible. For example:

- the reception area counter has been raised and a small Perspex screen put up and a trellis design built from the ceiling to reduce the open gap through which assailants could climb;
- bi-directional hinges have been fitted to the doors to prevent people barricading themselves in rooms;
- sofas have been used in many clinical areas instead of chairs, as there is less chance that they could be used or thrown in the event of an incident; and
- 'airlocks' at entrances have been installed to allow night staff to check visitors before admitting them into the hospital.

The Trust Executive made a corporate commitment to tackling violence and aggression and in April 2001 the Violence and Personal Safety Group was formed to address three issues of concern -

1. Development of policies - An overarching policy document was developed, supported by a series of detailed and specific guidelines. (For further details see www.zerotolerance.uk). Policies are stored in a dedicated folder on each ward/ unit. 'Collaborative working with the Police' guidance has been recently completed and a witness statement form, on which the doctor may professionally assess the patient's ability at the time to understand the implications and outcome of their actions has been developed.
2. Provision of overall advice - A Trust Advisor on Violence and Safety was appointed in the summer of 2001 to provide professional advice on safety issues and to co-ordinate training provided by the 9 part-time trainers. From April 2002, two full time violence and aggression trainers were recruited and attendance Violence and Personal Safety training courses at one of three levels is now mandatory for all staff.
3. Raise the profile of the zero tolerance zone campaign - Staff and service users were involved in devising the Trust statements on violence and aggression. This poster was meant to be more relevant to mental health services than the one used in the national zero tolerance zone campaign.

Outcome

The quality of reporting has improved. Staff are better at cataloguing the actual events so that the Risk Management team can analyse descriptions, rather than the perceptions of the incidents, and identify trends. The Violent Incident Monitoring group within the Forensic Directorate analyses how many times physical intervention is required, when staff intervene and what injuries occur. Over two years there was an 8 per cent reduction in the number of actual physical assaults reported, despite the increase in the size of the Trust.

Managers are assisted in auditing their general violence and aggression risk assessments of their wards or units to identify action points to reduce future incidents and periodic studies are made of the impact of potential risk factors such as non-regular staff members. Where it is appropriate, staff are encouraged to meet with the assailants/aggressor after the incident to talk it through and both staff and service users are entitled to post-incident support services.

The backlog of training required by staff has been reduced and around 50% of the nursing staff have completed the 10 day Management of Actual and Potential Aggression course. Two day training courses have now become standard within the Doctors' induction and ongoing training programme.

Source: National Audit Office survey

14 Measures taken to enhance security in Accident and Emergency Departments and Ambulances

Measure	% of Trusts	Comments	Evidence of Effectiveness
CCTV	92%	Already the most common form of security in many Trusts, and over 30% told us that they were considering improvements in both quality and coverage of CCTV. In addition 25% of ambulance trusts were using or trialling CCTV in their emergency vehicles.	A Home Office report: *Crime Prevention Effects of closed circuit television: a systematic review,* August 2002, noted that nine UK studies presented evidence that CCTV had a beneficial effect on the crime rate in town centres, reducing crime overall by 4 per cent. Five other studies, however, found that CCTV had no effect on violent crimes. Unless combined with on-site monitoring and response, CCTV is unlikely to offer any real security to staff, as the 'duration of combat' is usually 7 seconds and injury will occur in the first 3 seconds.[20] CCTV's value is in the public perception of security.
Panic buttons	85%	Panic alarms are commonly issued to staff working alone, however they do require that other staff including security staff are in a position, and have been trained, to react quickly and provide assistance.	Limited research on the impact of these security measures. In their report[20], Bleetman and Boatman were unable to draw any conclusions about the need for or efficiency of personal protective equipment and personal alarms.
Security staff	40%	Most common in inner city accident and emergency departments. Cover is seldom 24 hours, 7 days a week but is more comprehensive than that provided by the police.	The report[20] found only one example where high profile security presence was reportedly effective in reducing assaults (Case example 8) but identified concerns that such staff were not always trained appropriately. A few trusts mentioned problems of recruiting and retaining security staff. Overall, security guards can improve feelings of security and when dedicated to a specific work area can increase staff confidence.
A police presence	20%	In general, this involves the provision of a room which the police could use to detain violent or aggressive people. In most cases the police are present only during high-risk periods, particularly on Friday and Saturday nights.	The report[20] found that police presence was effective particularly in making staff feel safer. However there was no quantifiable evidence of effectiveness.
Other measures	17%	Other measures include keycoded door locks to restrict access, mobile phones for lone workers, particularly in the ambulance service, the use of security screens in reception areas and controlled access to sharps boxes.	Limited research on the impact of these security measures, however staff report feeling more secure as a result.

Source: NAO survey of NHS trusts

(f) The physical environment can have a strong influence on behaviour

3.34 Risk assessments recognise that long waiting times in drab surroundings and a failure to meet increasing patient expectations are important factors influencing the risk of violence[12,20,22,24]. Over half the NHS trusts in our survey of accident and emergency departments see the reduction of waiting times as essential if levels of aggression are to be reduced. **Figure 15** illustrates other measures some trusts are taking to improve the environment. While these environmental measures are generally believed to help reduce violence and aggression there is little substantial scientific evidence to support of this belief. Nevertheless there is growing belief that they make a positive contribution to the feelings and behaviour of people[24].

3.35 We found little evidence of evaluations by NHS trusts of the effectiveness of the various security or environmental measures. Without this, managers told us that they found it difficult to make a business case for more significant investment.

3.36 Nevertheless, there is increasing amount of literature that supports designing environments to combat crime and violence drawn from three sources: the planning and design of spaces; use of technical devices; and risk management. Greater emphasis is being put on passive measures for calming patients, on good observation and

Case Example 8

King's College Hospital NHS Trust

Situation In 2000-2001 the Trust recorded 840 incidents of assault and verbal abuse, of those 170 violent incidents were reported to the police and some 25 per cent resulted in arrest and about half were prosecuted. Growing concerns about the increase in the number of assaults led the Trust to take action to address the problem from a number of different angles.

Action taken The Trust has introduced a Security Control Room which monitors 140 CCTV cameras, a Pinpoint personal alarm system, panic alarms, Help Points and an emergency telephone line.

The in-house security team was recruited through a stringent selection procedure, and trained in control and restraint respond to all emergencies. The Trust estimate that they deal with about 75% of incidents without needing police support.

In cases of actual violence most suspects are detained and, when appropriate, police are called. The Trust operates a range of escalating measures against offenders including the withholding of treatment from violent individuals.

Outcome The Trust is widely regarded as an example of good practice. Violent incidents in 2002-03 are projected to fall for the third year in succession - a 33% reduction over the period. The Trust feel that this reflects their strategic approach to managing violence and aggression; significant investment in security measures, personnel and training; and a range of zero tolerance measures.

Case Example 9

Blackburn, Hyndburn and Ribble Valley NHS Trust's use of warning letters

Situation The Trust was concerned about a large increase in the number of incidents and in particular an increase in the number of serious threats and assaults.

Action taken A forum was set up to address the problem of violence against staff working at the Trust and this included representatives from the police, the Crown Prosecution Service and the local magistrates' court.

In December 1999, the Trust launched its own zero tolerance campaign with significant media coverage. If the manager/sister in charge of the department indicates on the incident report form that a warning letter should be sent in response to a violent incident, the Trust Security Manager would, via the Chief Executive send out a warning letter. If the same person re-offends, they would receive a second and final written warning via the Chief Executive. In extreme cases, following a second and final warning the Trust's solicitors would be contacted with a view to taking out an injunction to stop the person attending the Trust, except in an extreme medical emergency situation.

More widely, the Trust has funded a sub-police station adjacent to Accident and Emergency and the Security Manager liaises with the police after violent incidents. Regular dialogue with the Crown Prosecution Service aims to encourage a more active pursuance of prosecutions. Magistrates have amended sentencing guidelines for offences committed on hospital premises.

The Trust has set up a Security Working Group consisting of personnel from all levels and Directorates who are interested in improving security throughout the Trust. Security improvements are funded by all monies taken from car-parking fees.

Outcome Since 1999, 155 first warning letters and five second and final warning letters have been sent and one withdrawal of treatment letter has been used. Staff are fully supported by the Trust's Occupational Health Department and Security Manager. Help and advice on civil action was given in cases where a member of staff requested it, however most incidents (67) were dealt with via the Criminal Court. As a result the overall number of incidents has decreased by approximately 30 per cent.

Source: National Audit Office survey

15 Environmental, calming measures taken to reduce the risk of violence and abuse

Measure	Comments
Better communication with patients and relatives	Where delays are inevitable, Trusts are taking steps to improve communications by giving accurate information to patients about why they are waiting and what is going to happen to them. One key initiative for prioritising treatment is triage. Patients' lack of understanding of the process does cause problems and a number of Trusts have produced an explanation sheet. Others use information screens to update patient on likely waiting times. Any information has to be accurate and timely otherwise it could have a negative effect.
More pleasant environment	A number of Trusts have redesigned their accident and emergency department in calming colours, and tried to ensure that rooms are clean and tidy. Research projects have demonstrated the impact of colour on behaviour and some Trusts have used an art co-ordinator to provide a non-aggressive atmosphere. Environmental factors can trigger or exacerbate a potentially violent situation. Key issues to consider are space; seating; signage; temperature; cleanliness and clutter; lighting; access; and calming décor. Separate children facilities can reduce overall tensions.
Better facilities	This includes the provision of such items as televisions, music or newspapers in the waiting areas and ensuring that refreshments are available either by way of a counter service or through operational vending machines. However patient surveys generally give a low priority to such initiatives.

Source: NAO survey of NHS trusts Accident & Emergency Managers

communication, and on better training for staff to anticipate incidents, supported by less intrusive security measures to identify and record incidents[24].

(g) There is a wide variation in the extent to which the policy on withholding treatment is being applied

3.37 One of the more radical proposals to arise from the *zero tolerance zone* campaign was the policy for issuing written warnings to patients (yellow cards) culminating in withholding treatment (red cards) from patients who are repeatedly violent or abusive. This system, was pioneered at the Barts and the London NHS Trust in 2000-2001. In November 2001, the Department issued guidelines on "withholding treatment" which essentially extended the 'Barts' scheme across all NHS trusts[26]. As part of applying zero tolerance on violence against NHS staff, all trusts (except mental health trusts) must consider the need to develop a local policy on withholding treatment from violent and abusive patients. Such policies and procedures should form part of local policies addressing safer working conditions and should be in place by April 2002. This deadline was subsequently extended to 31 October 2002. The guidance exempted patients who are mentally ill and may be under the influence of drugs and/or alcohol, even though they are often the prime cause of incidents. Withholding treatment was acknowledged as being a last resort. Trusts were advised to seek legal advice in establishing their local policies.

3.38 We found that by April 2002, 39 per cent of NHS trusts had a policy and 44 per cent were still in the process of drafting one or discussing its appropriateness.

3.39 We also found that in practice NHS trusts are more likely to use warning letters from the ward or department in which the violence occurred or from the chief executive, pointing out that the patient's or relative's behaviour is unacceptable, but stopping short of actually threatening to withdraw treatment. Thirty-four per cent of accident and emergency department managers had issued warning letters on at least one occasion, 24 per cent had issued warning letters from the chief executive and 14 per cent had issued withdrawal of treatment letters.

3.40 NHS trusts that use warning letters generally consider this approach to be successful in bringing home to perpetrators that violence will not be tolerated and have achieved improvements in behaviour. In some trusts, the letters may include an invitation for the person to come into the hospital to give their side of the story. It is also seen as having a positive effect on staff morale by providing staff who have been subjected to violence or aggression with tangible evidence of the trust's prompt reaction to the incident. However, 16 per cent of all accident and emergency managers considered that the number of occasions on which letters were issued was less than appropriate. Case example 9 shows one Trust's approach to this issue.

(h) Many NHS trusts are developing close working relationships with the local police but these can falter over prosecutions

3.41 The campaign resource pack issued when the NHS *zero tolerance zone* campaign was launched[8,19], included guidance on making the best use of the criminal justice system and stressed the importance of close working relations with other agencies, including the police and the Crown Prosecution Service. This cross-Government approach was extended in September 2000 when new sentencing guidelines were issued to all Magistrates' Courts. These required factors, such as whether the offence occurred in hospital or medical premises and whether the victim was serving the public, to be taken into account as aggravating factors when passing sentence[27].

3.42 Our survey identified examples of close liaison between the police and NHS trusts through such measures as training (Case example 10), police rooms in accident and emergency (Case example 11), hot lines to police stations, and in the case of ambulance trusts, co-ordinated visits to potentially dangerous locations. In some 17 per cent of cases (27 trusts) the police maintain a permanent presence in the accident and emergency department at certain times, most commonly on Friday and Saturday nights.

3.43 The most frequent contact between NHS staff and the police occurs in the accident and emergency department. In our survey of NHS trust accident and emergency department managers 61 per cent considered police support to be satisfactory or very satisfactory. Among the issues raised by the remainder were:

- 12 per cent noted that police were generally willing to remove violent individuals from NHS premises, but often let them go once they were away from the hospital;
- 20 per cent reported that police appeared reluctant to press charges, and it was particularly difficult to convince the police to pursue a prosecution in cases where the individual was suffering from a mental condition irrespective of whether this had been a factor;
- police are often slow to respond, partly due to their own staffing problems (17 per cent), but accident and emergency is not seen as a public place and therefore not a priority (7 per cent); and
- police themselves are frustrated at the level of sentences and that staff themselves are often reluctant to act as witnesses (13 per cent).

3.44 Neither the Department nor the Crown Prosecution Service holds information on the numbers of charges brought against people committing acts of violence or aggression against NHS staff. A Nursing Times snapshot survey of six NHS trusts in April 2002 showed a variation in approach by the different trusts[50]. Of the three trusts that had seen an increase in rates, one had recorded 463 acts of violence in one year without any prosecutions, the second had taken out two prosecutions and two injunctions and the third had successfully prosecuted eight individuals and seen a decline in the number of physical attacks.

3.45 Our survey and literature searches confirm that prosecutions are rare, and where a case does get to court the sentence is often perceived to be light, for example in January 2003, a patient who assaulted a nurse at the Lakes Hospital Colchester, was fined £100 by Colchester Magistrates. The assailant was also ordered to pay £150 to the nurse who she had punched in the head and face. The NHS *zero tolerance zone* website includes other examples of successful prosecutions **(Figure 16)**.

3.46 In the event that the police or the Crown Prosecution Service decide that they are not able to prosecute it will generally be up to the individual who has suffered the violence to bring a civil action. But in doing so, they need the support of their NHS trust. Our survey showed that trusts have some way to go in adopting this approach: 30 per cent did not provide any support to staff wishing to prosecute and only 8 per cent offered support in all relevant cases. However, a number of trusts noted that although they would have been prepared to provide support, staff were frequently unwilling to launch actions citing, worries about the time the process would take, fears of having to be a witness and fears of possible retribution.

16 Examples of successful prosecutions by NHS trusts

- Blackburn, Hydburn and Ribble Valley NHS Trust - a man was given 12 months prison sentence for assault causing actual bodily harm to Accident & Emergency staff.
- London Ambulance Service NHS Trust - four months imprisonment for common assault by a patient in his home on two ambulance crew.
- East Anglian Ambulance NHS Trust - a man was sent to prison for four months for threatening paramedics with a crossbow and replica gun.
- Kettering General Hospital NHS Trust- a patient was given five months for punching a doctor and a guard.

Source: Department of Health zero tolerance zone campaign website www.nhs.uk/zerotolerance

Case example 10

University Hospital Durham Healthcare NHS Trust

Situation A serious incident in a local Accident and Emergency Department led to joint working with the police to formulate a policy to respond to such incidents of violence.

Action taken The empty Accident and Emergency Department of a new general hospital was used, before commissioning, for six training sessions to demonstrate police responses to a serious incident and to outline the basis of the policy. Each session ran a specific scenario to simulate an accident and emergency department running normally and included an incident where a patient produced a handgun and threatened patients and staff. The scenario training was also used to test current responses to violent incidents and to highlight strengths and weaknesses in those responses. The resulting joint policy should provide a rapid response to violent incidents, enable staff to deal more effectively with a violent situation and improve overall security.

Outcome As a result of this initiative the Trust felt that serious incidents have decreased, and more importantly staff felt that the Trust was taking their safety seriously. *Source: National Audit Office survey*

Case example 11

Partnership between the Royal Devon and Exeter Healthcare NHS Trust and the Devon and Cornwall Constabulary

Situation The Trust wanted to look at alternative methods to enable it to take forward the security provision, from the normal reactive role to a proactive role, in order to reduce crime and the fear of crime as well as empower the workforce.

Action taken An agreement was reached in 1995 between the Royal Devon and Exeter Healthcare NHS Trust and the Devon and Cornwall Constabulary to fund two police officers to patrol the Trust's sites exclusively. One of the first actions of the police officers was to carry out a full Crime Audit, from both police and Trust records. This was reinforced by the undertaking of a staff, patient and visitor Victim Survey, which looked at actual crime experienced on site, together with perceived fears both in and out of work. In addition to the directly paid for officers, the Trust has provided accommodation for a further 13 beat officers, thus increasing the visible presence of the Police around the site. Current changes to the layout of the Accident and Emergency Department include the provision of a dedicated police office, providing computer access to the Police network, which will allow officers' mobile access to make enquiries and complete their reports, without having to return to their station. The on-site police officers are also involved in the provision of awareness training for staff and are easily available to answer staff questions about personal security issues as they arise. A Security Forum, with representatives from the Devon and Cornwall Constabulary and across the Royal Devon and Exeter Healthcare NHS Trust, meets bi-monthly to monitor and review progress of security projects, discuss current security issues and recommend further improvements. The Forum has introduced an Exclusion Policy, which effectively bans those convicted of offences against the Trust, staff, patients and visitors. The Committee produces a departmental Security Manual, which provides basic security advice and details of excluded persons. This is supported by small passport sized guides to crime prevention, provided to all staff, to use as a quick reference.

Outcome The number of assaults and disorder incidents have increased from two each in 1995/96 to 8 and 26 respectively in 2000/01, however this is in large part due to the fact that the Trust's positive reporting and recording policies are working.

A reduction in crime of around 52% has been achieved over a five-year period as a result of the police patrols. Comments made by Trust staff as part of a follow-up survey in 2000 underline their support for and confidence in this initiative. 85% of respondents stated that having on-site police made them feel safer and the service they provide is beneficial to the community. Nevertheless, the Trust recognises that a more comprehensive investigation is required to establish the reasons behind relatively high levels of staff anxiety and concern for safety on site during the hours of darkness compared to levels during the day

Source: National Audit Office survey

3.47 These findings confirm those of the Royal College of Nursing *Working Well* survey in 2002[14], which found that in 5 per cent of case the incident was reported to the police and in 2 per cent of cases an offender was prosecuted. The College has called the failure to prosecute in zero tolerance the "missing link". Similarly a Nursing Times survey in April 2002 found that only 4 per cent of respondents had received support in pressing charges[50].

"Managers are failing nurses by not calling the police every time a violent incident occurs. The police are failing nurses by not taking the issue seriously. And Trusts are failing nurses by not prosecuting the attackers…" Nursing Times editorial - May 14 2002, Volume 98 No. 20

3.48 In response to concerns about the lack of prosecutions, the Department announced in June 2002 that the NHS *zero tolerance zone* guidance would be updated to state that "Trusts should consider with their lawyers, whether to bring a prosecution against an individual in cases where the Crown Prosecution Services decides not to". This was done through a revision to the Managers' Guide, issued in October 2002[19].

3.49 The Department has also updated the Managers' Guide to stress the need for NHS trusts to foster good relations with the police to help reduce violence against staff working in the NHS[19]. It emphasises that under the Crime and Disorder Act 1998, health authorities and Primary Care Trusts have a statutory requirement to co-operate with Crime and Disorder Reduction Partnerships and that the NHS has not universally made best use of this opportunity. There may therefore be scope for the NHS to learn from the way these partnerships operate in other sectors and benefits from sharing experiences with other sectors on a regular basis.

The Department disseminates good NHS practice but could learn more from other sectors

3.50 The report by the Chief Medical Officer, *An Organisation with a Memory*[28] and the subsequent report *Building a Safer NHS for Patients*[51] , noted that research and learning from failures in health care was relatively scarce. This has been redressed to some extent in relation to managing violence and aggression where the Department has been pro-active in promoting their approach through poster campaigns and in disseminating guidance and good practice through their *zero tolerance zone* website. The Department's *zero tolerance zone* campaign is seen as something of a trail blazer by other healthcare organisations. For example Scotland has modelled the relevant chapter in its manual on this approach and New South Wales has applied for a licence to use it in its health service.

3.51 A recent comparison of the 12 sets of guidance available in the United Kingdom, Australia, Sweden and the United States of America describes the Department's commitment to reducing the risk of violence as the most elaborated compared to other countries. Citing both the content of the guidance and the co-operation of government authorities and other stakeholders, the review concludes that there is no single guideline to promote as best practice and that though a campaign cannot be compared with a single guidance document, the *zero tolerance zone* campaign is the most comprehensive[29].

3.52 **Figure 17** provides examples of trends in the incidence of violence in the retail and transport sectors, the Employment Service and Benefits Agency together with examples of measures that they have taken to reduce the problem. These show that while most of the measures adopted to deal with the risks are similar to those used by NHS trusts, others such as local crime prevention partnerships that could be used more effectively than at present.

17 Other sectors use similar measures to the NHS to tackle violence and aggression

Sector	Incidence of violence	Measures taken
Retail trade	Prior to 2000, the level of violence had remained fairly stable for a number of years. In 2000 there was a slight increase and this has been followed in 2001 by a further sharp increase in violent assaults. Verbal abuse also increased although there was a decline in the number of staff subjected to threats of violence.	The establishment of retail crime reduction partnerships where retailers share information and photographs of known and suspected criminals, increased use of CCTV and exclusion notices which prohibit known criminals from entering the premises of the retailers.
Rail industry	Assaults on staff increased year on year between 1996/97 and 2000/01 by 73 per cent. The industry is subject to high levels of under-reporting and the incidence of violence and aggression is almost certainly higher.	More high profile policing of stations and trains and an increased use of CCTV. Plus a zero tolerance poster campaign.
London Underground Limited	Reported incidents of violence and aggression have risen by 75% over five years. Research found, in 2001-02, that the number of incidents is much greater than those reported 52: ■ 51% of staff are verbally abused and 28% are threatened at least once a week ■ 6% are physically assaulted at least once a month.	An integrated approach. Stakeholders are informed of the strategy and regular high profile poster campaigns are used. LUL amended recruitment processes and induction to give greater emphasis to the ability to deal with working pressures. A buddy system was introduced where adjacent stations check in with lone workers at regular intervals. Prosecutions are pursued by the British Transport Police and warning letters about unacceptable behaviour are issued. Civil actions are taken on behalf of employees and staff are informed of any general action taken as a result of incident reports.
Employment service/ benefits agency	Experience of violence and aggression had a negative impact on staff health and well-being and operational effectiveness. Adverse effects on staff absence were also noted. Reported incidents rose in both benefits offices and employment service offices between 1999 and 2000, in part due to the introduction of an improved reporting form and a campaign to encourage reporting. However the figures for 2001 showed a decline in both physical and non-physical assaults and this appears to have continued during 2002.	With the introduction of the Jobcentre Plus pathfinder offices, health and safety risk assessments have been conducted at each office. These have resulted in a range of measures: floor managers greeting customers and guiding them through their visit; comprehensive CCTV coverage; security guards with clear instructions as to when to intervene; and screen facilities to deal with situations likely to give rise to particular risk.

Source: National Audit Office review of industrial and service sectors

Appendix 1

Committee of Public Accounts Report recommendations compared with findings of National Audit Office's 2002 examination

Relevant conclusions from Committee of Public Accounts 2nd Report Session 1997-98 on NHS Acute Trusts	Findings from National Audit Office's 2002 examination covering acute, mental health and ambulance Trusts
(i) We are concerned that hospitals are dangerous places for patients, staff and visitors … we note that the large number of accidents imposes a significant burden on NHS resources which could be better spent on patient care.	The throughput of patients in the NHS has continued to increase, increasing the risk of an incident occurring. A number of measures have been taken to reduce risks but there is still a need to improve information on extent and costs (Part 2). There is also little evidence based on information on what works and what does not.
(ii) We consider it unsatisfactory that despite the Executive's[a] previous guidance many hospitals do not have accident recording systems which provide accurate and timely information … also concerned at very wide differences in accident rates recorded … and the difficulties in making comparisons because of under-reporting.	There has been a positive response to the need to improve reporting by trusts. However, there is still a wide variation in the standards of reporting, different definitions are being used and under-reporting remains a problem, particularly of verbal aggression. This has affected the reliability of baseline information and makes it impossible to judge whether the reported increase reflects an actual increase in incidents and measure how trusts, individually and overall, are performing (paragraphs 2.6-2.17).
(iii) We consider it vital that trusts have accurate and up to date information to help them assess health and safety risks, to identify, … action … needed to reduce these risks, and to minimise costs … We … expect all NHS Trusts to introduce …accident recording systems which meet the principles set out in the Comptroller and Auditor General's report.	All trusts now have an accident recording system however the type and data collected vary. There is evidence of improved reporting of violence and aggression, greater use of risk assessment but little or no information on costs. Under-reporting is still a problem (paragraphs 2.22-2.23 and 2.13-2.17).
(iv) We are concerned that some staff may be discouraged from reporting accidents. We look to NHS Trusts to take a stronger lead in encouraging their staff to report all accidents promptly.	The operational risk management tool was not produced. However, the Department continues to disseminate good practice examples through its zero tolerance zone website.
(v) We are disturbed by the low and variable levels of trusts' compliance with health and safety legislation and that the Executive were unaware of this state of affairs. We consider it highly unsatisfactory that the health sector reports to the Health and Safety Executive only 37 per cent of the accidents which it is legally required to report.	The Health and Safety Executive's 2000/01 letter to chief executives of trusts noted that all 33 trusts visited during the year had made some progress in developing policies, assessing risk and implementing controls, although the level of compliance continued to be patchy. Nevertheless, compliance with legislation still varies between trusts **(Appendix 4)**.
(vi) We note the Executive's view that the position has improved since the removal of Crown immunity but we consider there is a long way to go before the NHS can demonstrate an acceptable level of performance in this area.	The Health and Safety Executive's RIDDOR data indicates that reported accidents involving assault or violence to employees in trusts between 1998/99 and 2001/02 fluctuate year on year but that the highest recorded total was in 2000/01. Also, the number of improvement notices linked to violence and aggression that they have issued has increased **(Appendix 4)**.

[a] *The Executive referred to is the former NHS Executive which was the executive arm of the Department of Health and which now forms an integral part of the Department of Health.*

Relevant conclusions from Committee of Public Accounts 2nd Report Session 1997-98 on acute Trusts	Findings from National Audit Office's 2002 examination covering acute, mental health and ambulance Trusts
(vii) We are concerned … [about] limited action on the part of trusts in response to … volume of guidance issued … by the NHS Executive … [and] surprised that there has been little effective check on whether trusts are implementing [it]. We do not regard it as acceptable for the Executive to rely on the Health and Safety Executive on this issue.	The Department has issued a plethora of guidance on violence which has raised awareness (Appendix 2). The NHS reorganisation under Shifting the Balance of Power12, has meant that regional offices have not carried out their performance management role. The Department is therefore unable to evaluate, in any meaningful way, progress against the national targets (20 per cent reduction by March 2002 and 30 per cent by March 2004).
(viii) We expect trusts to draw up detailed plans for achieving full compliance with legislation … trust boards should regularly review progress against such plans. We recommend that the Executive should review the progress made by trusts in implementing these arrangements.	Inspection of compliance has improved. The Health and Safety Executive has increased its scrutiny of trusts (Appendix 4) and the Commission for Health Improvement inspects compliance with the implementation of non clinical risk assessments. Trusts also undertake self assessments of the health and safety Controls Assurance statement.
(ix) We consider it essential that hospitals should be made safer places to be treated in, to work in, and to visit. We welcome the high priority which the Executive has given to health and safety issues in 1997-98 and their pledge to act on all of the recommendations contained in the Comptroller and Auditor General's report.	There have been numerous initiatives by the Department (Appendix 2). In 1999 the Health and Safety Executive amended the *Management of Health and Safety at Work Regulations 1992* re-enforcing the need for trusts to use risk assessments to evaluate health and safety risks 36. The Health and Safety Executive inspectors have also made healthcare a priority programme as part of the Government's Revitalising Health and Safety Strategy and are focussing on violence as one of the key risks (Appendix 4).
(x) We note the action take in the trusts visited by the NAO and District Audit to put in place improvements in their recording and management of health and safety. We look forward to seeing further significant improvements in performance across all NHS Trusts over the next year.	All trusts have improved their incident recording systems although the types used vary. The NHS *zero tolerance zone* campaign website provides a number of examples of good practice in developing effective incident recording systems.
(xi) We note that the Executive are seeking better collection and analysis of data on accidents at local level coupled with voluntary benchmarking of … performance. We see these as important and helpful mechanisms in helping trusts to assess and to improve their performance … we are doubtful whether it is sufficient to rely on voluntary benchmarking … look to the Executive to explore ways of ensuring that all trusts participate.	The Department's *Working Together* targets are essentially a benchmarking exercise. Again the *zero tolerance zone* website contains examples of good practice.
(xii) We note the work … [of] the Executive in developing further guidance … focusing on areas where the health service is particularly vulnerable. We also note … guidance in the past has had a limited effect. We therefore urge the Executive to consider alternative ways of securing greater awareness and the implementation of good practice, … setting up a small team of experts to visit trusts and provide on the spot practical advice.	The Department has issued detailed guidance on managing violence and aggression (Appendix 2). In particular, the Home Office, the Lord Chancellor and the Attorney General supported the launch of the NHS *zero tolerance zone* campaign and in September 2000, new sentencing guidelines were issued which take into account whether the offence occurred in hospital or medical premises and whether the victim was serving the public. In addition, a number of trusts have developed local partnerships with the police (paragraphs 3.42 -3.50).

Appendix 2

Key Department of Health initiatives aimed at reducing and ultimately preventing violence and aggression against NHS staff

Guidance/initiative	Key messages
June 1997: NHS Health and Safety Issues HSG(97)6	Required NHS trusts to implement the National Audit Office recommendations and to put in place policies and procedures to investigate, record, monitor, review and assess causes and costs of incidents, sickness absence, ill health retirement and occupational health.
April 1998, HSC 1998/064 - *Management of Health, Safety and Welfare Issues for NHS staff*	Updated guidance for employers on the provision of Occupational Health Services and reminded them of their duty to comply with health and safety legislation.
September 1998, launch of the strategy *Working Together - securing a quality workforce for the NHS*	Frank Dobson, then Minister of State for Health, gave a commitment to measuring progress in the management of Human Resources including monitoring against National Improvement Targets for reducing incidents of violence and aggression.
March and October 1999 - HSC 1999/079 and 1999/229: *Working Together - securing a quality workforce for the NHS*	HSC 1999/079 -Specified the targets that the NHS must achieve: reduce levels of sickness absence and incidents of violence to staff by 20% by 2001 and 30% by 2003. HSC 1999/229 re-emphasised the targets, included an additional target on staff accidents and specified actions that NHS trusts needed to take including reporting systems using a common definition and publishing incident reduction strategies.
October 1999: launch of NHS *zero tolerance zone* campaign	The *zero tolerance zone* campaign was launched by the then Minister of State for Health, John Denham, with the support of the Home Secretary, the Lord Chancellor and the Attorney General. The aim being to make the public understand that violence against staff working in the NHS is unacceptable and that the Government (and the NHS) is determined to stamp it out. Also to get over to all NHS staff that violence and intimidation is being tackled.
October 1999 - HSC 1999/226: *Campaign to stop violence against staff working in the NHS: NHS zero tolerance zone*	Requires NHS trusts to support the NHS *zero tolerance zone* by raising awareness of the campaign amongst all staff groups and ensuring that the campaign posters were prominently displayed in public waiting areas and staff rooms. Also that trusts should involve staff in developing local policies addressing safe working conditions, including a full assessment of the risks to staff; and work closely with the police to develop local prevention and reduction strategies. The National Improvement Targets on reducing violence underpinned the campaign.
October 1999 - April 2000 - Phase I of *zero tolerance zone*	The launch of the initiative was supported by a campaign resource pack containing a range of publicity material and guidance for managers and staff with the message "We don't have to take this". The packs also contained guidance on risk assessment and prevention and the need to work with the Police and Crown Prosecution Service. In addition, Home Office funded, joint road-shows were held in every Region to promote the role of NHS in local crime reduction partnerships.

Guidance/initiative	Key messages
April - October 2000: Phase II of *zero tolerance zone*	Aimed at maintaining the high profile of zero tolerance. Included: ■ a distance learning package for nurses, developed jointly with the Royal College of Nursing; ■ guidance documents to support staff working in NHS mental health and ambulance trusts, in the community and in Primary Care; ■ the launch of a dedicated NHS website www.nhs.uk/zerotolerance which contains resource materials and specific examples of successful action undertaken by trusts throughout the country; and ■ new sentencing guidelines reflecting cross-Government approach to zero tolerance, issued to all Magistrate's Courts.
Health Service Circular 2000/030: *the Human Resources Performance Framework*	The Framework was intended to support the NHS in measuring and maintaining progress on the strategic aims of *Working Together*. NHS trusts and Regional Offices were required to determine and agree targets to ensure that the national targets for reducing violent incidents were met. Regional Offices were expected to monitor local progress and co-ordinate the sharing of good practice.
March 2001 -Phase III of the *zero tolerance zone* Campaign	The Department re-launched the *zero tolerance zone* poster campaign in March 2001 with new posters detailing newspaper clippings of assaults and prosecutions "We don't have to take this and we didn't". The Department also placed a series of articles and advertisements in the Nursing Standard and the British Medical Journal to encourage more reporting of incidents by staff.
July 2001: the new Health and Social Care Awards included a zero tolerance category	The awards were introduced in order to recognise achievement in tackling violence against staff working in the NHS. These were given to Barts and the London NHS Trust and University Hospital of North Durham Healthcare NHS Trust . www.doh.gov.uk/healthandsocialcareawards.
November 2001, Phase IV - HSC 2001/18: *Withholding Treatment from Violent and Abusive Patients in NHS Trusts*	All trusts, except mental health trusts, must consider the need to develop local policies and procedures for withholding treatment from patients in place by April 2002. The guidance also announced that central funding of £1.5 million over three years was available to support local NHS initiatives to tackle violence against staff and that this was to be allocated through the Improving Working Lives initiative.
September 2002 - Phase V - Dealing with Harassment by NHS Service Users - A guide for managers and staff	Launched by the Minister of State for Health, John Hutton, as a further phase of the *zero tolerance zone campaign*. Headed "The true cost of harassment" under the premise that there is no place for discrimination and harassment of NHS staff by service users on any grounds. Also that the employer has a statutory duty to protect all employees against bullying and harassment as far as is reasonably practicable.
October 2002 - Updated Managers Guide - Stopping Violence Against Staff Working in the NHS - "We don't have to take this"	John Hutton, Minister of State for Health, issued the updated Managers' Guide which reflected some of the developments that have occurred since the launch of the *zero tolerance zone campaign*. It emphasised the need to ensure that all incidents are reported, including where appropriate to the police and to strengthen arrangements for liaising locally with the police.

Appendix 3 National Audit Office Study Methodology

The key features of our methodology were:

- A survey conducted between June and September 2002, of all 270 NHS acute, mental health and ambulance trusts in England, to establish information about a range of health and safety issues. In relation to violence and aggression the survey sought information on trends in the levels of incidents, the assessment and management of risks, guidance and training given to staff , the protective measures undertaken by trusts and the support provided by them to staff who had experienced violence. The survey was carried out on our behalf by our consultants, Taylor Nelson Sofres Social Research and had a 98 per cent response rate (265 trusts).
- A follow-up survey of 166 NHS trust accident and emergency department managers (October 2002) to pursue specific issues linked to the management of violence and aggression (55 per cent response rate) and a follow-up survey of 282 trust health and safety leads to collect 2001-2002 incident data (98.5 per cent response rate).
- An interrogation of relevant databases, interviews and file examinations at the Department of Health, the Health and Safety Executive, the Commission for Health Improvement and selected NHS trusts.
- Visits to a number of relevant parties, including public and private sector bodies with experience of managing the risk of violence and aggression.
- Information provided by the NHS Litigation Authority, the NHS Pensions Agency, Crown Prosecution Service and the Home Office.
- An extensive literature review and attendance at a number of conferences dealing with health and safety and violence and aggression issues.
- An expert panel, which we consulted throughout the study. A full list of its members is attached at Table A.

The full details of our methodology, including the survey questionnaires, are on our website www.nao.gov.uk. The results from our surveys have been shared with the Department of Health. NHS trusts who took part in our survey will be provided with an individual feedback report.

Table A: Membership of Expert Advisory Group

The NAO is grateful to the members of their expert advisory panel who have provided advice and guidance throughout the Value for Money investigation.

Dr Robert Ll Davies	Head of Health, Safety and Environment Unit, University of Wales College of Medicine Chair of the Health Care group at the Institution of Occupational Safety and Health
Stuart Emslie	Head of Controls Assurance, Department of Health
Helen Hughes	Director of Operations, National Patient Safety Agency
Ann Macintyre	Director of Human Resources, Barts and the London NHS Trust
Peter McKenna	Senior Nurse Manager in the Accident and Emergency Department, Medway NHS Trust
Lynn Parker	Clinical Nurse Infection Control Specialist, Northern General Hospital NHS Trust Representing the Infection Control Nurses Association
Dr Linda Patterson	Medical Director, Commission for Health Improvement
Jon Richards	Assistant National Officer, Health Care Group, UNISON
Chris Taylor	Principal Inspector, Health Services Unit, Health and Safety Executive
Judy Thurgood	Head Occupational Therapist, Heatherwood and Wexham Park NHS Hospitals Trust Representing the College of Occupational Therapists
Professor Brian Toft	Research Director, Marsh Risk Consulting
Julian Topping	Senior Business Manager, NHS Employment Policy Branch, Department of Health
Tony Bleetman	Consultant in Accident and Emergency Medicine, Birmingham Heartlands Hospital (co-opted onto Expert Panel to provide advice and guidance on violence and aggression)

Appendix 4 The Health and Safety Executive

1. The Health and Safety Executive (HSE) recognised work-related violence as a serious health safety matter in the early 1980s. Various reports and studies have documented the risks of violence within the workplace, and all have highlighted the negative and costly impact it can have on staff and on society as a whole. There are no specific regulations on work-related violence, and HSE encourages employers to manage it in the same way as any other risk covered by health and safety legislation[35,36]. HSE guidance published in 1989, *Violence to Staff*, provides advice on how to address these issues in the workplace. Further guidance published in 1997, *Violence and Aggression to staff in health services*, from the Health and Safety Commission's Health Services Advisory Committee also provides primary and secondary care services with a framework for managing these risks systematically[46].

2. HSE measure the health and safety performance of the NHS in a number of ways, no one of which is entirely satisfactory. NHS Trusts are required, under legislation, to report to the HSE all work-related accidents to staff which result in more than three days absence from work - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR). This provides a reasonably consistent measure of certain accident types. HSE have also estimated the degree of under-reporting from separate sources such the Labour Force Survey which show that the health sector had relatively high rates of under-reporting (estimated level of reporting - 42 per cent).

3. Work-related violence has been included within the definition of 'accident' since 1995. Violent incidents at work are the third greatest cause of reported injuries to health care staff under RIDDOR. In addition to the physical effects, violence and aggression are a major cause of stress to health care staff.

4. According to the NHS's own surveys, violent or abusive incidents in NHS trusts, which include verbal abuse, increased in English trusts and health authorities from approximately 65,000 in 1998/99 to 84,273 in 2000/01 (As detailed in this report, the NAO survey found incidents in NHS trusts had increased still further to 95,501 in 2001-2002). HSE figures for accidents that resulted in more than three days absence from work, show a general increase in injuries from assaults from 1996 onwards, although there was a reduction in 1999/2000 which seems to have been repeated in the provisional figures for 2001/02. One explanation of this is that trusts may be starting to manage or prevent serious physical assaults against a background of increasing violence.

5. The Health and Safety Commission are also undertaking a three year programme of work which began in April 2000, to address work-related violence, with an aim of reducing the incidence of violence at work by 10% by the end of 2003. A particular aim of the programme is to draw together complimentary activities and strategies such as the Department of Health *zero tolerance zone* campaign, which has made considerable progress in raising awareness of work-related violence. Work is in hand to report on the achievements of the programme.

6. In addition, HSE has funded the Employment National Training Occupational Standards in Managing Work-Related Violence. The Employment National Training Organisation has responsibility for developing national occupational standards, and working with awarding and accrediting bodies to develop and implement National and Scottish Vocational Qualifications. The Standards were launched in September 2002, aim to help employers to draw up policies on managing work-related violence, and provide a framework for managers and staff to assess training needs.

Accidents and assaults to NHS staff in England reported to HSE under RIDDOR.

	1996/7	1997/8	1998/9	1999/00	2000/01(i)	2001/02p
Assaults causing Major Injuries	67	82	67	62	82	64
All Assaults	744	723	766	705	846	759
All Accidents	7500	7231	7112	6841	6732	5992

p=provisional figures

Note

(i) 2000-01figures follow the launch in 1999 of the Department of Health's *zero tolerance zone* campaign

Enforcement Activity

7. HSE inspections of NHS trusts since 1996 have focused on a number of key risks, one of which has been violence. The table below shows the numbers of Improvement Notices (under the *Health and Safety at Work etc Act 1974* [35]) served on trusts since 1998 to improve their management of violence and aggression.

HSE Improvement Notices Served on NHS trusts since 1998

Year	Total Notices in the NHS	Notices in the NHS served during the inspection programme	Notices on violence served during the inspection programme
1998/99	133	93	9
1999/00	162	84	8
2000/01	208	65	4
2001/02p	212	81	12

p = provisional figures

8. The increased number of Notices served in 2001/02 can in some part be attributed to the specific health services priority programme which targeted health care settings and also as a result of a high profile first prosecution of an NHS trust over the management of work-related violence. In August 2002 a community trust was convicted under the *Health and Safety at Work etc Act 1974*[35] following serious assaults on two support workers by a patient. The trust was fined £12,000, and HSE was awarded costs of over £14,600.

Other Findings from HSE Inspections

9. The findings from HSE inspections of the management of violence reflect HSE's general conclusions on health and safety in NHS trusts: slow overall progress since 1996/97; some trusts with excellent policies and practice, but others with wholly inadequate systems; little communication of good practice; and inconsistencies in approach even within trusts.

10. Almost all NHS trusts treat violence and aggression as a significant issue, but show wide variations in tackling it and in the effectiveness of their precautions. Matters of concern still being identified in 2001/02 were:

- no risk assessments for areas of work or activities where staff were at risk from violence;
- no systems for implementing the outcomes of assessments;
- low levels of awareness of trust policies; and
- inadequate training in managing violence and aggression, or un-trained staff (e.g. porters) being required to handle violent patients.

11. HSE inspectors have identified some examples of good practice in managing violence and aggression in NHS trusts. These have included trust-wide security and anti-violence programmes; joint initiatives with local police forces; developing new training programmes for staff in handling violence and aggression; and re-designing the layout of mental health units. Similar examples have been used in the Department of Health's *zero tolerance zone* campaign material.

Appendix 5 Violence in the workplace

What constitutes workplace violence?

Workplace violence and aggression includes a wide range of unacceptable behaviour beyond the obvious physical assaults. While any definition of violence must clearly include incidents leading to death or injury where medical assistance is required, it can also include threats and threatening behaviour, verbal abuse and harassment. Workplace violence and aggression can include:

Incidents of violence and aggression need not be restricted to the workplace but can occur anywhere in the community or at the home of the employee. The incidents would still be considered as work-related if they arose out of the course of the employee's work.

Physical violence	Non-physical violence
■ Assault causing death	■ Verbal abuse, swearing or shouting, Name calling and insults
■ Assault causing serious physical injury (requiring hospital treatment)	■ Racial or sexual harassment
■ Minor injuries (requiring first aid)	■ Threats- with or without weapons
■ Physical attack not causing injury (kicking, biting, punching)	■ Physical posturing and/or threatening gestures
■ Use of weapons and/or missiles	■ Abusive telephone calls or letters
■ Sexual assault	■ Bullying
	■ Deliberate silence

The legal requirements in respect of workplace violence

All employers, including NHS trusts, have duties in respect of work-related violent incidents under both national and European health and safety legislation and under the common law duty of care. The employers' duties under health and safety legislation are general and cover all risks including that of workplace violence. The key requirements on employers are:

Health and Safety at Work etc. Act 1974

Employers have a duty to protect the health and safety of their employees and the health and safety of others who might be affected by the way they go about their work.

The Health and Safety Executive has powers to carry out inspections of workplace activities; issue Improvement or Prohibition Notices requiring changes to be made to work activities, and initiate criminal court proceedings for alleged breaches of health and safety legislation.

Management of Health and Safety at Work Regulations 1992, amended in 1999

Employers have a duty to assess all risks to the health and safety of their employees; identify the precautions needed; make arrangements for the effective management of precautions; appoint competent people to advise them on health and safety; and provide information and training to employees.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995

Employers have duty to report all cases in which employees have suffered death or major injury or have been off work for three days or more following an assault which has resulted in physical injury.

Safety Representatives and Safety Committees Regulations 1977, and Health and Safety (Consultation with Employees) regulations 1996

Employers have a duty to consult with safety representatives and employees on health and safety matters.

Crime and Disorder Act 1998

Establishes local Crime and Disorder partnerships led jointly by police and local authorities. They have a statutory duty to develop and implement a strategy to tackle crime and disorder in their area in consultation with a wide range of local agencies including health, education, the private and voluntary sectors and the wider community. The Police Reform Act 2002, extends responsibility to fire and police authorities and provides for future inclusion of Primary Care Trusts.

Health Act 1999

The Commission for Health Improvement has powers to review clinical governance arrangements in NHS organisations, and require that the organisation formulate an action plan to deal with any problems identified.

In addition, under common law, an employer must take reasonable care to protect employees from the risk of a foreseeable injury, death or disease.

Certain work-related factors affect the level of workplace violence in the healthcare sector

1 working with the public,

2 working with distressed or unstable people (either patients or their relatives/carers),

3 working with people who are under the influence of drugs or alcohol,

4 working the late hours of the night or the early hours of the morning,

5 handling prescription drugs,

6 providing care or advice, and

7 working in community based settings.

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