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Protecting NHS Trust staff from violence and aggression



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I have prepared this report for presentation to the National Assembly under the Government of Wales Act 1998.

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Report presented by the Auditor General for Wales to the
National Assembly on 22 September 2005



	Summary	6
	Recommendations	8
1	Part 1: The risk, impact and cost of violence and aggression is variable across NHS Trusts, but the statistics are incomplete	10
	Although violence and aggression is not a major problem for most NHS Trust staff, the risk is higher for some staff in particular Trusts and setting	12
	Reported numbers of incidents vary widely by service area	14
	Reported numbers of incidents vary by staff group with nurses experiencing the majority of incidents	23
	Violence and aggression has a range of costs to staff and the NHS in Wales	24
	The statistics are incomplete because Trusts use different definitions and there is under-reporting	26
	The statistics are incomplete because Trusts use different definitions and there is under-reporting	26
2	Part 2: Although the Welsh Assembly Government and NHS Trusts have generally taken steps to prevent incidents of violence and aggression, there remains scope for further improvement	28
	The Welsh Assembly Government has generally taken positive steps to address violence and aggression	28
	NHS Trusts have improved their management of the risk of violence and aggression, but there remains scope to improve their handling of incidents when they occur, train staff and work with other agencies	32

Appendix 1		
Scope and methodology		46
<hr/>		
Appendix 2		
Incidents of violence and aggression at NHS Trusts in Wales in 2003-04		47
<hr/>		
Appendix 3		
Amount spent on violence and aggression training in NHS Trusts in Wales		48
<hr/>		
Appendix 4		
Comparative data on violence and aggression in Wales, England and Scotland		49
<hr/>		
Appendix 5		
Violence and aggression policy in Scotland		50
<hr/>		
Appendix 6		
Definitions of violence and aggression in use in Wales		51
<hr/>		
Bibliography		53



Summary

- 1** Regrettably many people face the risk of violence and aggression at work, particularly in the NHS. According to the British Crime Survey, nurses working in the health service were over three times more at risk of assault than teachers, and faced a risk of threats at work around twice as high as teachers. In 2003-04, NHS Trust staff reported around 8,000 incidents of violence and aggression, the equivalent of 22 incidents occurring each day somewhere in Wales.
 - 2** Despite the steps taken by the Welsh Assembly Government and NHS Trusts to reduce the risk of violence and aggression, the Health and Safety Executive issued five improvement notices to Welsh NHS Trusts in the four years to March 2005 because of inadequacies in their management of the risk of violence and aggression.
 - 3** This report examines whether the Welsh Assembly Government and NHS Trusts have gripped adequately the problem of violence and aggression against staff. We found that:
 - a** NHS Wales generally understands the extent of the problem of violence and aggression, although the statistics are incomplete because of under-reporting and inconsistent definitions. There is particularly high incidence of violence and aggression against nursing staff; while there are also high levels of violence and aggression in adult mental health, general medicine and learning disabilities services; and
 - b** the Welsh Assembly Government and NHS Trusts have taken action to tackle violence and aggression, particularly the development of the violence and aggression passport and Trusts' work to comply with HSE improvement notices. Nevertheless, there remains scope to improve arrangements to deal with incidents when they occur; provide training for staff; and work with others to prevent incidents from occurring and to deal with incidents once they have occurred.
 - 4** Our more detailed findings are as follows:
- ### The extent of the problem
- Although violence and aggression is not a major problem for most NHS Trust staff, the risk is higher for some staff in particular Trusts and settings**
- 5** In 2003-04, NHS Trust staff reported 7,971 incidents of violence and aggression, of which they reported 66 to the Health and Safety Executive. Trust staff said that they viewed violence and aggression as one of the major health and safety issues facing them. We found considerable variation in the incidence of violence and aggression, with five times as many reported incidents of violence and aggression per member of staff in some Trusts than others.
 - 6** The incidence of violence and aggression varies by service area, with particular problems in mental health services, general medicine and learning disabilities. The impact of violence was also high in Welsh Ambulance Services NHS Trust, where nearly half of all incidents resulted



in injury to the staff member. Similarly, there is considerable variation by staff group, with over three quarters of incidents affecting nurses, midwives or health visitors, who made up 47 per cent of all Trust staff at the end of September 2004.

- 7 Obviously there is a high personal cost, both emotional and physical, of violence and aggression against individual members of Trust staff. It also presents costs to the NHS although these are hard to quantify. Violence and aggression can affect recruitment and retention in particular departments. And the costs of staff absence, security staff, legal services and training amounted to some £6.3 million in 2003-04.

Trusts have used inconsistent definitions of violence and aggression and under-reporting remains a problem

- 8 Effective management of violence and aggression in the NHS requires accurate measurement. Yet we found weaknesses in the consistency both of definitions and reporting. Although most Trusts used similar definitions of violence and aggression, a small number used different definitions that did not cover verbal abuse. The violence and aggression passport scheme, which provides guidance on the management of such incidents, recommends a common definition that should facilitate more consistent measurement.
- 9 Only nine out of fifteen Trusts could provide information about the nature of each reported incident for 2003-04. Such weaknesses in recording and reporting compromise Trusts' efforts to protect their staff from the risk of violence and aggression. Trusts now expect to be able to analyse their incidents by service area for 2004-05. We are concerned about evidence of

under-reporting of incidents by dental and medical staff and in accident and emergency departments.

Scope for further action

The Welsh Assembly Government has taken steps to address violence and aggression, particularly by introducing the violence and aggression passport

- 10 NHS Wales staff developed the All Wales NHS Violence and Aggression Training Passport and Information Scheme, which the Welsh Assembly Government launched in September 2004. This provides detailed guidance in key areas and reduces the risk of duplicating training. In addition, the Welsh Risk Management Standards provide a framework to improve Trusts' management of the risks associated with violence and aggression.
- 11 Since effective health and safety management depends fundamentally on full and transparent reporting, there are risks in setting quantitative targets for reducing numbers of reported incidents. Nevertheless, in the 2003-04 financial year, the Welsh Assembly Government set Trusts a target to reduce by 10 per cent the number of reported incidents of violence and aggression between 2002 and 2004, based on a Health and Safety Executive target. In the event, Trusts could not provide the Welsh Assembly Government with clear baseline data against which to measure progress, so it was impossible to monitor compliance with the target. The Welsh Assembly Government has therefore helped to strengthen the framework for managing the risk of violence and aggression by abandoning this target.

Although NHS Trusts have improved their management of violence, there is scope to improve the handling of incidents when they occur, the provision of training and working with other agencies


- 12** The Health and Safety Executive issued improvement notices to five Trusts between April 2001 and March 2005; these Trusts subsequently took satisfactory remedial action. We found that NHS Trusts have all established clear frameworks to manage the risk of violence and aggression, although we found weaknesses in some procedures applying to lone workers. The passport provides further guidance on lone worker policies and procedures and, together with development of a new all Wales lone worker alert system, should help Trusts to protect lone workers more effectively.
- 13** All Trusts offer appropriate levels of training, although some Trusts have difficulty in releasing staff for training, a situation that may worsen with the increased demand for training created by the passport. Some Trusts have addressed this problem by providing training at the weekend.
- 14** No employer, particularly in a high-risk sector such as healthcare, can ever eradicate violence and aggression. Consequently, it is essential that Trusts develop robust systems to handle incidents after they occur. Trusts provide a range of support systems, which include independent counselling, referral to occupational health and support from managers. Some Trusts also provide security staff in high risk areas, such as accident and emergency, to deal with incidents when they occur, although not all of these Trusts have trained their security staff in dealing with violence.

- 15** Trusts work with other agencies to deal with serious incidents. Trusts told us that there are problems securing appropriate action against offenders and all said that they would like more support in gaining convictions for serious incidents, or against repeat offenders. There are further problems in sharing information about known offenders between agencies, such as social services, general practice and other Trusts.

Recommendations

The Welsh Assembly Government and Trusts should address high-risk areas

- i** Persistent offenders are responsible for a large proportion of incidents of violence and aggression in some settings. Consequently, Trusts should seek to reduce the risk of violence from persistent offenders by developing individual risk assessments for high risk health service users; sharing appropriate information about such individuals with other agencies; and working closely with the police to reduce the risk from such individuals.
- ii** Given the prevalence of violence and aggression in mental health settings, all Trusts should reassess the risk in this setting, and implement the best practice set out in the Healthcare Commission's recent review of violence in mental health settings.
- iii** Because of the weaknesses in existing arrangements for monitoring the safety of staff in the community (in some cases relying on family members or friends to raise the alarm if an incident occurs), all NHS Trusts should develop policies and procedures which actively monitor the personal safety of



lone workers and include a clear escalation procedure of steps to take if there is a risk that an incident might take place.

Trusts should strengthen their arrangements for reporting and recording incidents of violence and aggression

- iv** Trusts told us that they did not know how many staff were absent from work due to violence and aggression. Trusts should identify and measure work-related sickness absence that results from violence and aggression to staff.
- v** It is imperative that staff at all levels report all incidents of violence and aggression. Trusts should develop reporting arrangements which are simple, clear and, in particular, encourage medical staff to report all incidents, especially in fast-moving service areas such as accident and emergency. Within this culture of full reporting, Trusts should classify all reported incidents by staff group and setting. To ensure that staff can see clear benefits in reporting all incidents, Trusts should feed back regularly to staff the results of their analysis of incidents on a Trust wide basis.

Once there are common definitions and more robust systems for reporting and recording incidents, the Welsh Assembly Government and Trust boards should monitor levels of violence and aggression

- vi** The Welsh Assembly Government should avoid using quantitative targets, which might discourage full reporting and recording of violent incidents. Instead, it should focus on the framework supporting Trusts in managing the risk of violence and aggression and dealing effectively with incidents when they occur.

- vii** The Welsh Assembly Government should require Trusts to provide annual reports of violent incidents. The Health and Social Care Department should monitor and analyse trends and use the data to provide policy support to NHS Trusts in their protection of staff against violence and aggression. Likewise, all NHS Trust boards should receive reports on the extent of violence and aggression in their Trust at least annually, monitor trends and take firm action to protect staff in high risk areas.

The Welsh Assembly Government and Trusts should further improve access to training for staff

- viii** Trusts should clearly identify their overall training priorities by service area and staff group. Trusts should make it easier for busy staff to access training, for example by developing more flexible course scheduling or delivery mechanisms.
- ix** In accordance with the Welsh Risk Management Standard in security, Trusts should provide appropriate training in the management of violence and aggression for their security staff.



Part 1: The risk, impact and cost of violence and aggression is variable across NHS Trusts, but the statistics are incomplete

- 1.1** Staff providing health services should be able to go about their work unhindered by the fear of verbal abuse or physical assault by patients or their relatives and friends. The British Crime Survey found that, in 2002-03, 3.3 per cent of health and social welfare associated professionals, including nurses, midwives and paramedics, experienced one or more assaults at work. This was the second highest rate for all occupations. The latest All Wales NHS Staff Opinion Survey, carried out in 2002, found that while violence and intimidation was not viewed as a problem by the majority of staff, there were concerns among staff in some high-risk areas. Trust health and safety staff told us that they viewed violence and aggression as one of the leading issues for health and safety, together with manual handling.
- 1.2** Although violence and aggression between people is a universal problem, there are particular and varied reasons why violence and aggression is prevalent in healthcare settings. It may be triggered by too much ward activity, denial of service, overcrowding, inadequate facilities or negative staff attitudes. Drugs and alcohol also play a part as they may make someone more aggressive, lower inhibitions so that people act unpredictably and make it difficult for de-escalation techniques to work. Staff have said that the 'rights culture', associated with the patients' charter, can also cause problems as it has raised expectations among patients which Trusts may not be able to meet due to high levels of demand for services at a particular time.
- 1.3** Employers have a duty to comply with laws and regulations which protect their employees, and others using their premises, from a range of

health and safety risks, including violence and aggression. **Figure 1** shows the framework of civil legislation covering health and safety which the Health and Safety Executive enforces through a programme of routine inspections and investigations of specific incidents.

Figure 1. The legislative framework governing health and safety at work

Health and safety legislation places many important responsibilities on employers to protect their staff and others using their premises. Under the **Health and Safety at Work Act 1974**, employers have a legal duty to ensure, so far as is reasonably practicable, the health, safety and welfare at work of their employees. **The Management of Health and Safety at Work Regulations 1999** also require employers to consider the risks to employees, including protecting employees from exposure to reasonably foreseeable violence. Employers must:

- establish the significance of the risk of violence and aggression;
- identify what can be done to prevent or control the risk; and
- produce a clear management plan to achieve this.

If employers are found not to meet the relevant statutory provisions, the Health and Safety Executive can issue them with an **improvement notice** which states what they need to do to remedy the situation within a particular timescale.



Where there is a risk of serious personal injury if the employer continues to operate, a **prohibition notice** can be served which states that an activity must be stopped until the situation is remedied. If the employer fails to comply with the terms of a notice then a prosecution will normally follow with maximum penalties on conviction of a heavy fine and/or up to two years imprisonment.

Any accident at work affecting an employee resulting in death, major injury or incapacity for normal work for three or more days must be reported to the Health and Safety Executive under the **Reporting Injuries, Diseases and Dangerous Occurrences Regulations 1995** usually referred to as **RIDDOR**. This includes acts of violence against staff.

Employment law, as stated in the Employment Rights Act 1996, and contract law together bring obligations to the employer to provide a safe working environment, including protection from violence.

Source: Bill Fox, Charles Polkey and Peter Boatman of Maybo Limited. Tolley's managing violence in the workplace. Reed Elsevier (UK) Ltd 2002 and Health and Safety Executive

1.4 The Health and Safety Executive has a programme of work to address violence and aggression in the NHS in Wales to contribute to its *Revitalising Health and Safety* agenda (see Figure 2).

Figure 2. Programmes being undertaken by the Health and Safety Executive to address work-related violence and aggression

Revitalising Health and Safety is a ten year campaign to reduce all work-related incidents of ill-health by 20 per cent, fatal injuries and major injuries

by 10 per cent, and days lost from work related injuries and ill-health by 30 per cent by 2010, with half of these targets to be achieved by 2004. The health services sector is a priority area and progress against the targets is being monitored nationally by the Health and Safety Executive. Overall, at their first stage of monitoring in 2004, they found no evidence of any change in work-related ill health since 1999-2000, or any reduction in the number of working days lost.

Work related violence. The Health and Safety Executive has published case study guidance, commissioned research to find examples of good practice in preventing and managing violence to lone workers, and funded the development of new National Occupational Standards in the management of work-related violence. These standards were published by the Employment National Training Organisation in September 2002 and provide employers with a framework on which to develop detailed policies on work related violence. The Health and Safety Executive is evaluating the progress of the first stage through monitoring of data in the British Crime Survey but has not yet reported on it. Programmes currently being undertaken by the Health and Safety Executive relating to work-related violence are to:

- commission research and disseminate good practice guidance on the effectiveness of current violence and aggression training programmes and guidance for commissioners of training to select suitable and competent training providers; and
- share information on strategies and approaches to secure compliance with health and safety regulations on work-related violence.

1.5 Under criminal law, the police and Crown Prosecution Service may prosecute those who infringe the law on public disorder, assault, threats or harassment depending on the severity of the incident and the likelihood of a conviction. Alternatively, the police may issue a warning or a formal caution. Criminal cases have to be proved beyond reasonable doubt, so there must be clear and reliable evidence that an offence was committed. The Code for Crown Prosecutors sets out public interest factors in favour of prosecution. It states that: “a prosecution is likely to be needed if... the offence was committed against a person serving the public (for example, a police or prison officer or a nurse)”. If an assault case is proven, then magistrates can award the victim compensation for personal injury, loss or damage up to a total of £5,000 for each offence.

1.6 If the case was not taken under criminal law, the victim of an assault could take a case for compensation against the perpetrator under civil law; make a civil claim for compensation through the courts against their employer if the employer was negligent; or seek compensation through the Criminal Injuries Compensation Scheme. In a civil case, alleging negligence on the part of the employer, the injured party would need to prove that the employer had not done everything reasonably practicable to prevent the violence from occurring. Therefore, NHS Trusts need to do all that they can to assess and reduce the risk of violence and aggression towards their staff.

1.7 NHS Trusts can also make use of anti-social behaviour legislation under the Crime and Disorder Act 1998 and the Anti Social Behaviour Act 2003. This legislation allows for an anti-social behaviour order (ASBO) to be taken out in a magistrates’ court against an individual whose

behaviour causes alarm, distress or harassment, such as those who persistently instigate violence in the health service. The prohibitions in the ASBO are preventative in nature and are intended to put an end to persistent and serious criminal or sub-criminal behaviour. North Glamorgan NHS Trust has made use of this legislation and works with other local agencies, such as housing and social services, which may have problems with the same individual. The process brings together the agencies that can help to tackle an offender's pattern of behaviour through remedial action to help and support, rather than punish, the offender.

Although violence and aggression is not a major problem for most NHS Trust staff, the risk is higher for some staff in particular Trusts and settings

NHS Trust staff reported 7,971 incidents of violence and aggression in 2003-04

1.8 The Welsh Assembly Government has not developed a full picture of the levels of violence and aggression across NHS Trusts. Our survey provides the first all-Wales data on the number of incidents of violence and aggression reported between the 2001-02 and 2003-04 financial years. Whilst paragraphs 1.30 to 1.35 show that staff are not reporting all incidents and that Trusts do not use consistent definitions, these figures still provide a good indication of the overall extent of the problem facing staff in Trusts.

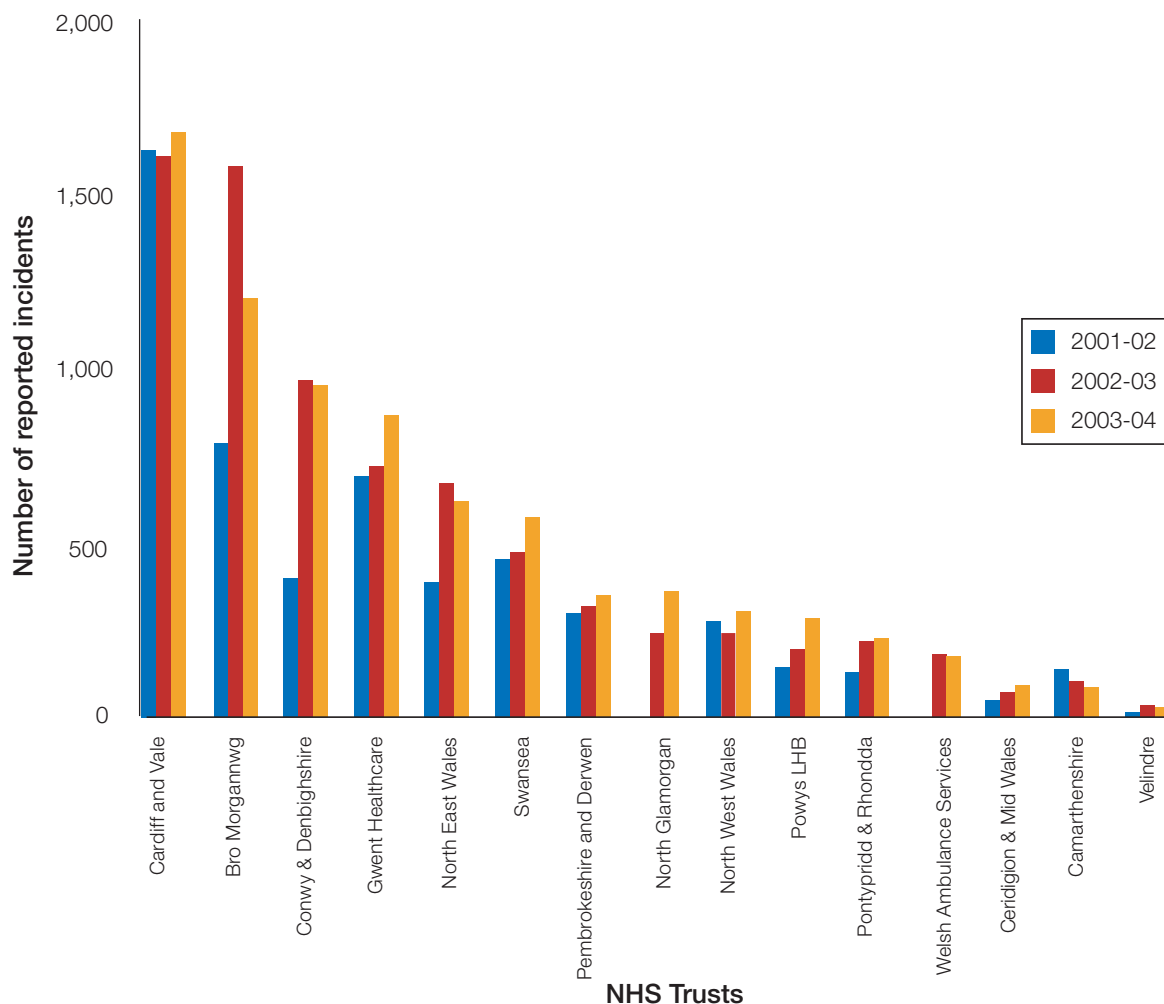
1.9 Trust staff reported 7,971 incidents of violence and aggression in 2003-04, a 2 per cent increase on the 7,793 incidents reported in 2002-03. There were 5,520 incidents reported in 2001-02; however, a number of Trusts told us that figures for that year were unavailable,



covered less than the full year, or were incomplete. Figure 3 shows that there were wide variations in the numbers of incidents of violence and aggression reported between 2001-02 and 2003-04, both within Trusts and between Trusts. The introduction of new reporting systems and the encouragement of full reporting may help explain the very high

increase in the number of incidents reported by some Trusts between 2001-02 and 2003-04. For example, after Powys Local Health Board introduced a new reporting system in 2002-03, their figures almost doubled.

Figure 3. Number of incidents of verbal abuse and physical assault reported by staff at NHS Trusts



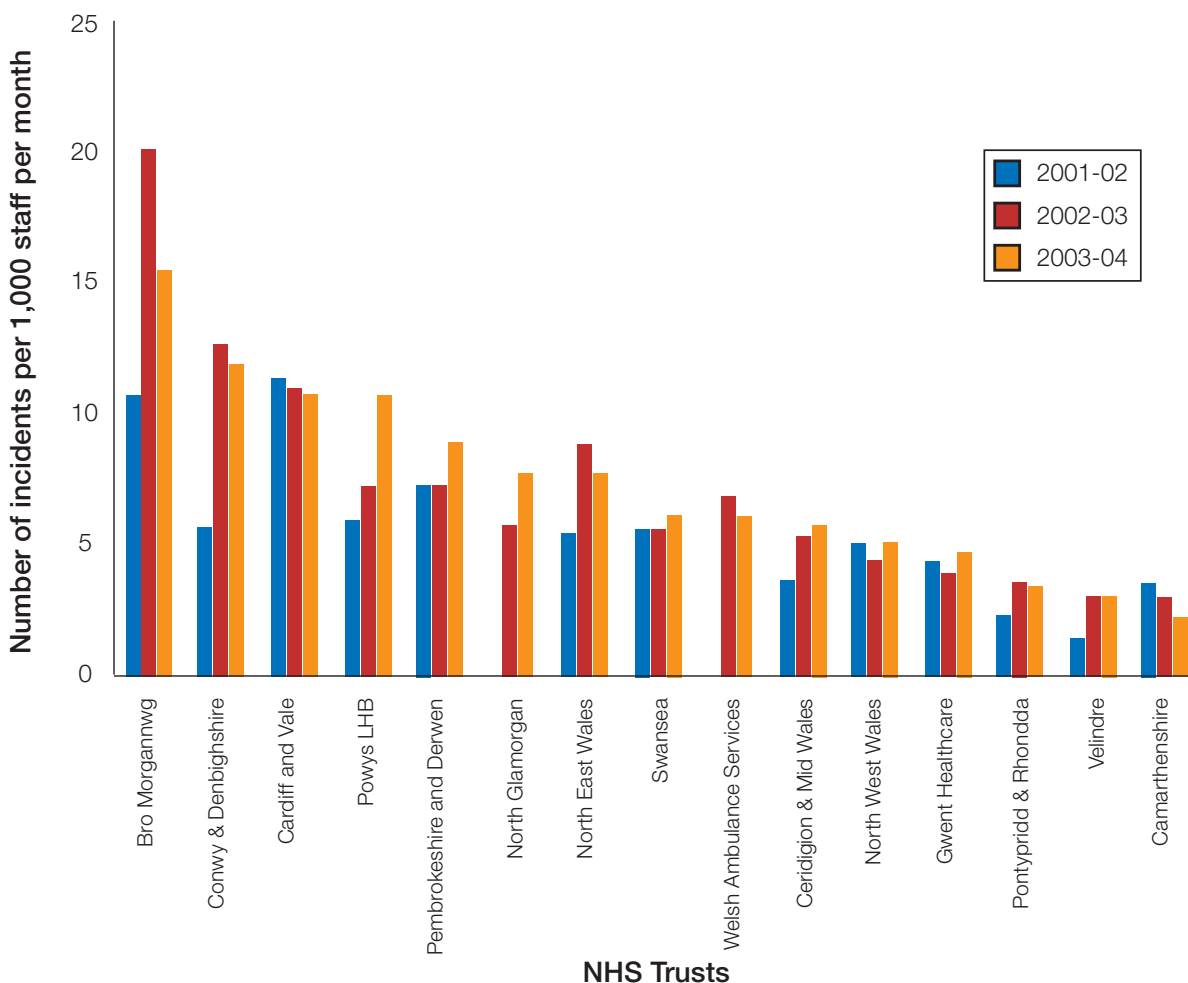
Note: North Glamorgan and Welsh Ambulance Services NHS Trusts were unable to provide us with data for 2001-02

Source: Wales Audit Office survey of all NHS Trusts and Powys Local Health Board

1.10 To reflect the size of different Trusts in Wales, it is important to relate the statistics in [Figure 3](#) to staff numbers. [Figure 4](#) shows that Bro Morgannwg, Conwy and Denbighshire, and Cardiff and Vale reported the highest number of incidents per 1,000 staff per month in 2003-04. The rates of the highest reporting Trusts were five times higher than the lowest. All of the eight NHS Trusts with six or more incidents per 1,000 members of staff per month provide mental health services and five of them also provide learning disabilities services (see [Appendix 2](#)).

Both of these services are known to experience high rates of violence (see paragraphs 1.17 to 1.18 and 1.21). Bro Morgannwg NHS Trust told us that they provide two specialist services for the whole of South Wales: learning disabilities services and forensic mental health services. Persistent offenders are another cause for concern. For example, Conwy and Denbighshire told us that, in 2002-03, three patients in acute services accounted for 38 reported incidents, whilst in the community six patients accounted for 183 reports.

Figure 4. Number of incidents of verbal abuse and physical assault per 1,000 staff per month



Note: North Glamorgan and Welsh Ambulance Services NHS Trusts were unable to provide us with data for 2001-02

Source: Wales Audit Office survey of all NHS Trusts and Powys Local Health Board



1.11 We cannot conclude that the Trusts with the highest levels of reported incidents per 1,000 staff per month in [Figure 4](#) have the biggest problem with violence, as it may be that they have better systems in place to record incidents such that their staff feel more able to report incidents than those at other Trusts. However, a single incident of violence against a member of NHS staff is one too many, and Trusts must do whatever they can to protect staff from this risk. The overall figure for violence and aggression against staff in Wales was 7.6 per 1,000 staff per month for 2003-04. The most recent comparator with England is 2002-03, when staff in Wales experienced 8.3 incidents per 1,000 staff per month compared with an average of 11 across all Trusts in England. Appendix 4 provides a comparison of the overall rates of violence and aggression in Wales, England and Scotland.

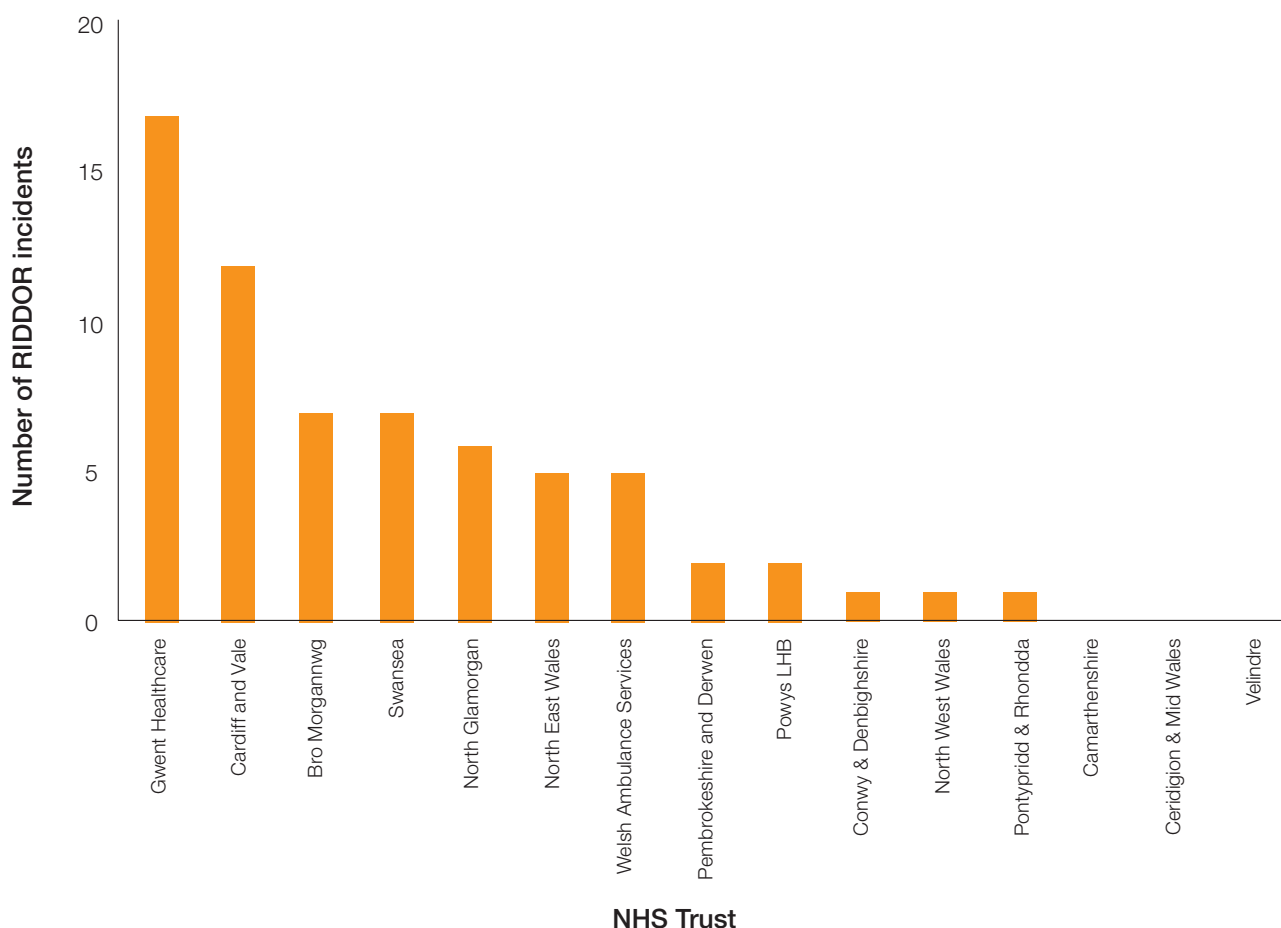
1.12 Only nine of the fifteen NHS Trusts were able to provide us with information about the nature of each reported incident, covering just over one third (38 per cent) of incidents in Wales. In these nine Trusts, over half (56 per cent) of reported incidents in 2003-04 were classified as verbal abuse, agitated behaviour, threatening behaviour, sexual or racial harassment, and 42 per cent were physical or sexual assaults with the remaining two per cent being other unspecified incidents. These figures may reflect the increased likelihood of physical assaults being reported compared with verbal abuse. Trusts told us that their figures are becoming more reliable, which should facilitate the production of more robust data. The introduction of new software by a number of NHS Trusts should enable those Trusts to analyse their incidents in more detail from 2004-05.

Trusts reported 66 incidents of violence and aggression to the Health and Safety Executive in 2003-04

1.13 Under the Reporting Injuries, Diseases and Dangerous Occurrences Regulations 1995 (known as RIDDOR), employers must report to the Health and Safety Executive any incidents of the following nature:

- death or major injury connected with work; and/or
- an accident connected with work (including an act of physical violence) where the injured person is away from work, or unable to carry out their full range of duties, for more than three days.

Figure 5. Violence and aggression RIDDOR incidents in 2003-04 reported by NHS Trusts in Wales



Source: Wales Audit Office survey of all NHS Trusts and Powys Local Health Board

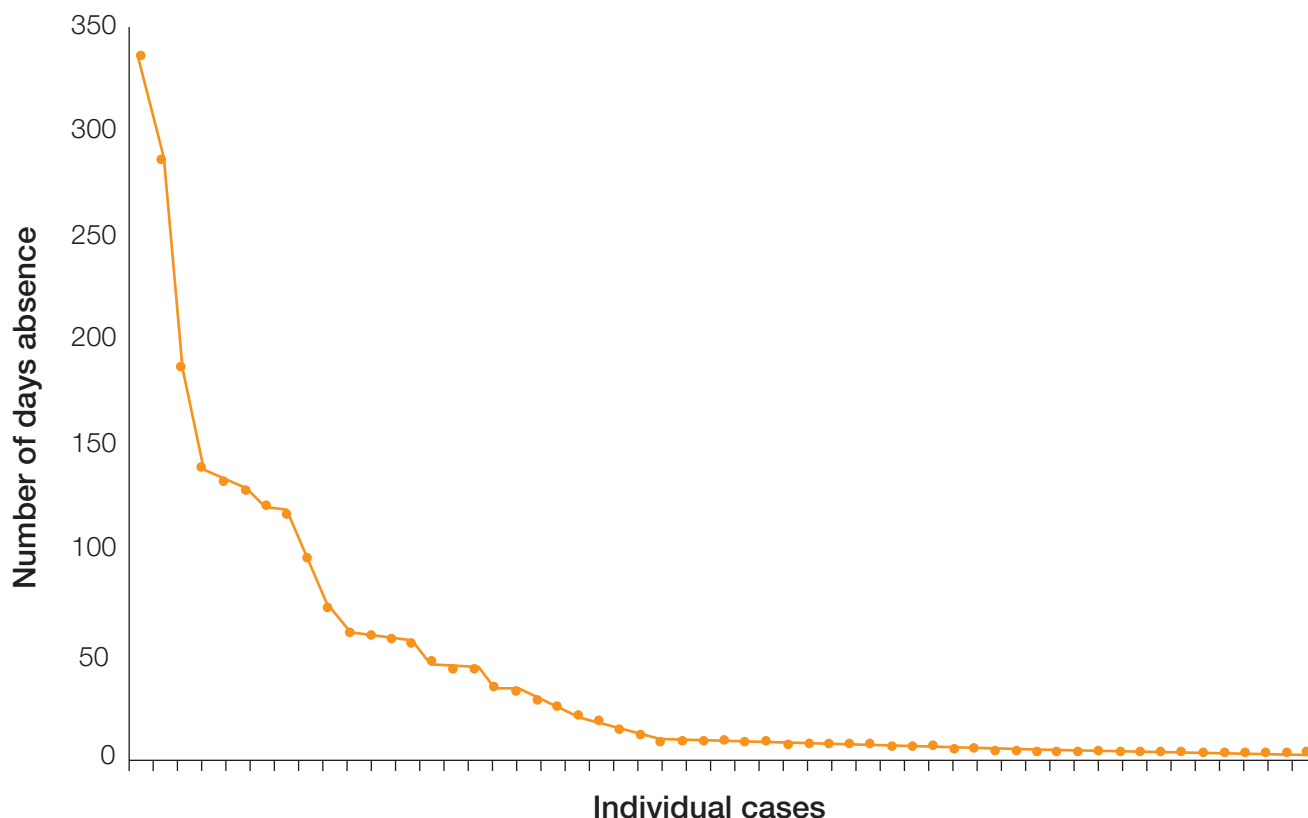
1.14 RIDDOR incidents are likely to represent more serious incidents occurring in Trusts, although they are unlikely to pick up on incidents where staff suffer a delayed reaction to one or more incidents and are absent due to stress. Figure 5 shows that 12 NHS Trusts in Wales reported a total of 66 RIDDOR incidents relating to violence and aggression to the Health and Safety Executive in 2003-04, while three Trusts reported no RIDDOR incidents. Of these incidents, seven were major injuries, while the remaining 59 led to absences of over three days.

1.15 By 30 June 2004, RIDDOR incidents of violence and aggression, occurring between 1 April 2003

and 31 March 2004, had accounted for a total of 2,404 days' staff sickness absence. Figure 6 shows the distribution of duration of sick leave arising from incidents of violence and aggression reported to the Health and Safety Executive; in three cases staff have been absent for more than six months, while the median is ten days (that is, the values at the midpoint of the range). In 2003-04, less than one per cent of recorded incidents of violence and aggression actually resulted in sick leave of over three days, of which one third led to long-term sickness absence of 28 days or more.



Figure 6. Duration of sickness absence arising from each incident of violence and aggression, reported by NHS Trusts to the Health and Safety Executive, between 1 April 2003 and 31 March 2004



Source: Wales Audit Office survey of all NHS Trusts and Powys Local Health Board

Reported numbers of incidents vary widely by service area

1.16 The incidence of violence and aggression within NHS Trusts varies by service area or department. [Figure 7](#) illustrates three areas with high levels of recorded incidents while [Figure 8](#) shows that, overall, the highest numbers of incidents are in adult mental health, followed by general medicine and learning disabilities services. [Figure 9](#) shows that adult mental health has by far the highest number of RIDDOR incidents although levels of RIDDOR incidents

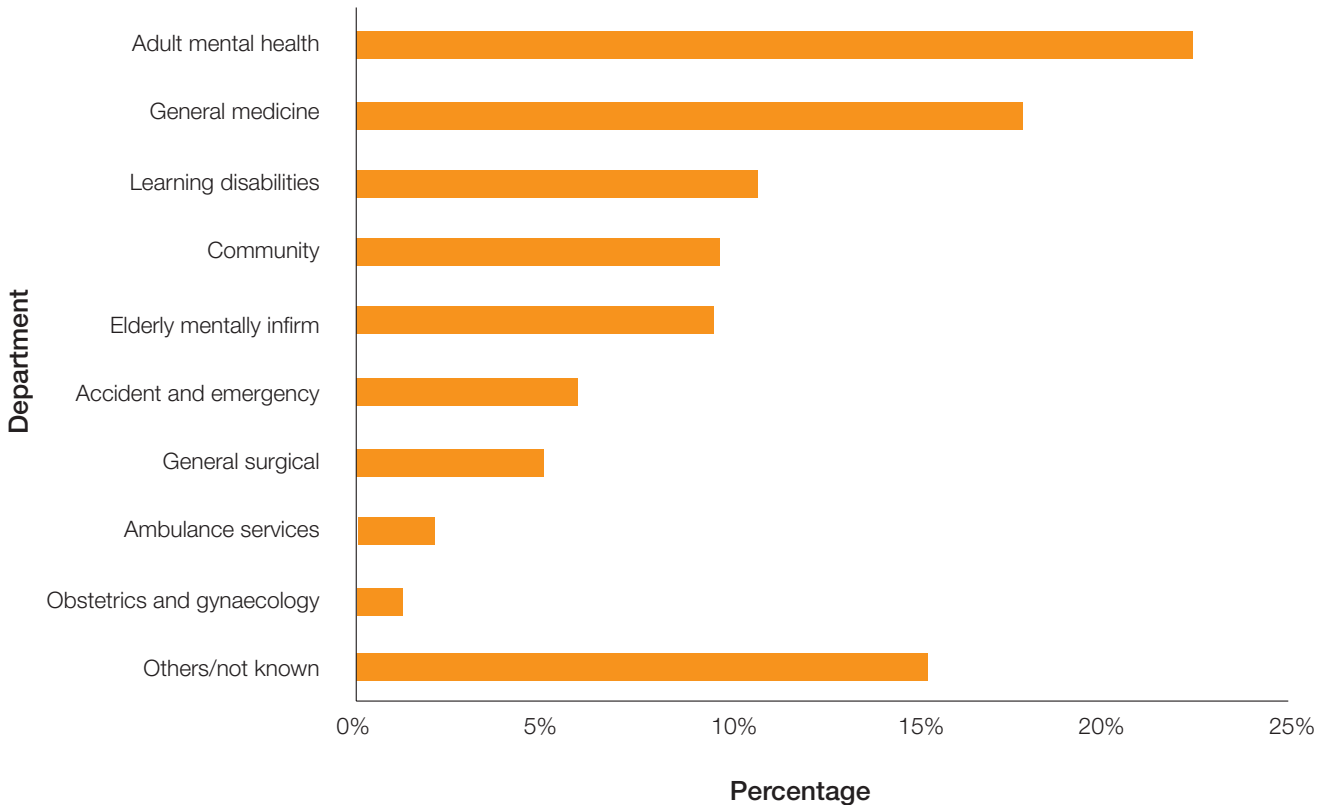
were also high in learning disabilities services. Appendix 2 provides a more detailed breakdown of the number of incidents in each service area by NHS Trust. The following section of the report discusses each main service area in more detail.

Figure 7. NHS Trust departments with high levels of recorded violence in 2003-04

- a** general medicine at Cardiff and Vale NHS Trust reported 664 incidents (47 per cent of all general medicine incidents in Wales);
- b** mental health at Conwy and Denbighshire NHS Trust reported 470 incidents (26 per cent of all mental health incidents in Wales); and
- c** learning disabilities at Bro Morgannwg (who provide services for NHS Trusts across south Wales) reported 467 incidents (54 per cent of all incidents in learning disabilities in Wales).

Source: Wales Audit Office survey of all NHS Trusts and Powys Local Health Board

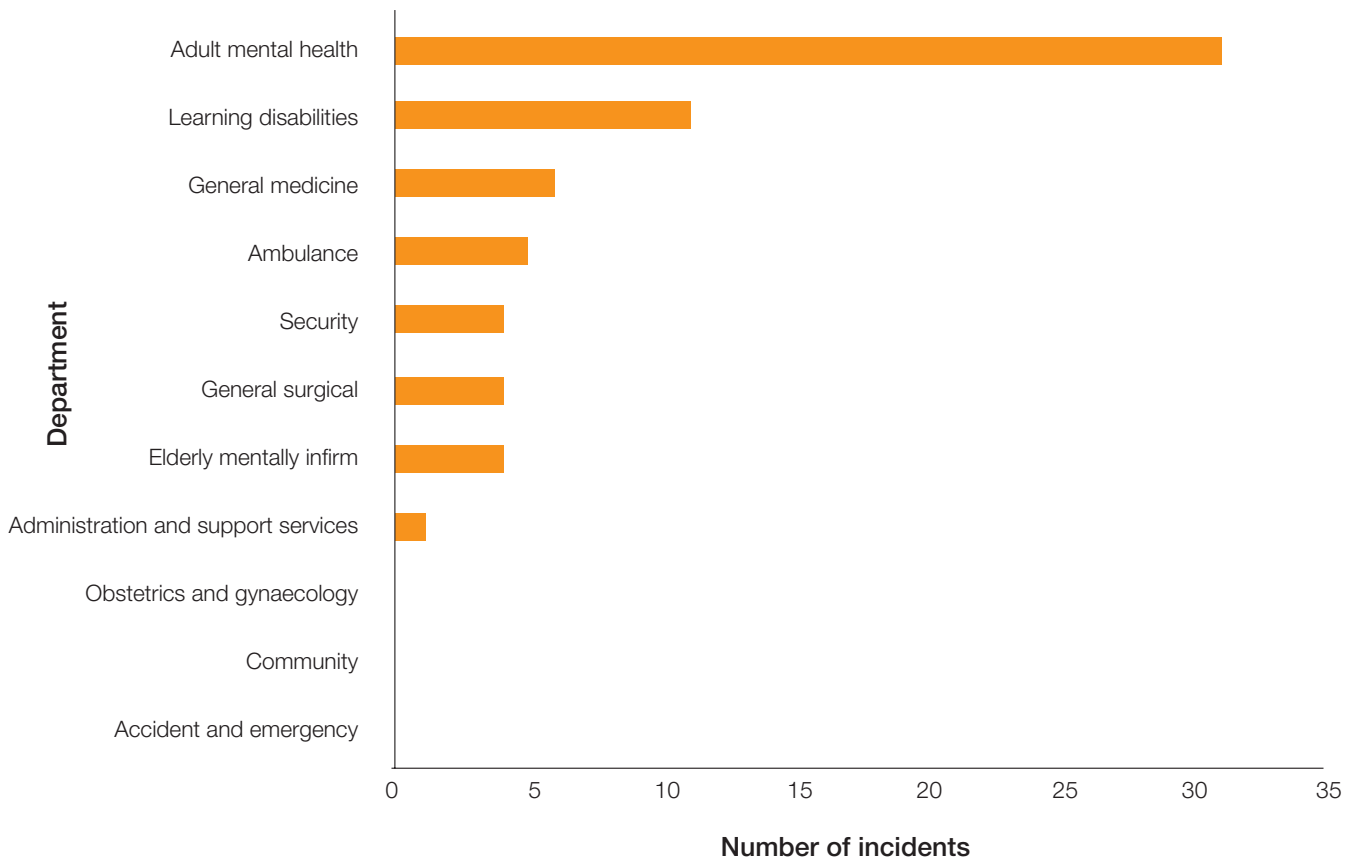
Figure 8. Percentage of incidents reported in each department by NHS Trusts in Wales for 2003-04



Source: Wales Audit Office survey of all NHS Trusts and Powys Local Health Board



Figure 9. Number of RIDDOR incidents by department, 2003-04



Source: Wales Audit Office survey of all NHS Trusts and Powys Local Health Board

Staff working in mental health services have the highest risk of incidents

1.17 Figures 8 and 9 show that the most incidents took place in mental health settings in 2003-04 (23 per cent of all incidents and 31 RIDDOR incidents). The Health and Safety Executive reported that the RIDDOR incident rates for violence in mental health Trusts in England are around two and a half times the average for all Trusts. In Wales, there are three times as many RIDDOR incidents in mental health compared with general medicine and general surgery combined.

An occupational therapy technician was working with an elderly person with dementia. The patient had previously been verbally abusive but on this

occasion lunged forward, knocked the member of staff to the floor and landed on top of her. The technician suffered injuries to the neck, head, shoulder and right arm.

Source: Welsh Health Legal Services

1.18 Many complex factors cause people with a diagnosis of mental illness to commit acts of violence. Although the vast majority of people with mental health problems are not violent, aggressive behaviour may be a symptom of a small number of individuals' conditions which may be directed against themselves or others. Furthermore, people with a dual diagnosis of both mental illness and substance misuse are much more likely to perpetrate violence than

people with a single diagnosis of mental illness. **Figure 10** presents the main factors that influence violence in mental health settings as reported by the Royal College of Psychiatrists' national audit of violence in England and Wales (see **Figure 19** for details of participation in the audit by NHS Trusts in Wales).

Figure 10. The Royal College of Psychiatrists' National Audit of Violence: Factors influencing violence in mental health settings

- a** **Unsafe environments** – many of the wards and units surveyed failed to meet basic safety standards. There were also problems with excessive noise and uncomfortable temperatures which both caused unease for service users;
- b** **inadequate staffing** – there were staff shortages in many of the wards and units caused by staff moving to community settings and difficulties in recruiting staff. This leads to an over-reliance on bank and agency staff making it difficult to build a coherent team;
- c** **client mix and overcrowding** – many acute mental health services are struggling to cope with high bed occupancy rates and increasingly unwell service users;
- d** **substance misuse** – this was identified as the most common trigger for violence with alcohol causing particular problems in acute mental health units. Some staff felt powerless to stop people coming back to the ward drunk or high on drugs, or to stop the dealing of drugs on the ward;

- e** **smoking** – lack of cigarettes, overcrowded smoking rooms and annoyance at the smoking behaviour of other people on the ward;
- f** **high levels of boredom** – many wards and units are unable to offer service users a structured and therapeutic system of care with particular problems at weekends. Reasons given by staff were the low staffing levels and high volumes of paperwork;
- g** **medication and treatment** – side effects, compliance with the medication prescribed or changes in treatment; and
- h** **staff training in the prevention and management of violence** – significant numbers of staff were dissatisfied with the training available and were unable to apply it to real life situations.

Source: Royal College of Psychiatrists' College Research Unit in conjunction with the Healthcare Commission, The National Audit of Violence (2003-2005): final report. May 2005.

Violence and aggression is a problem in certain areas of general medicine and general surgery, particularly with confused elderly patients

1.19 **Figure 8** shows that general medical wards accounted for 18 per cent, general surgical wards for five per cent, and accident and emergency accounted for an additional six per cent of all incidents recorded in 2003-04. **Figure 9** shows that six RIDDOR incidents, (where staff were away from work for three or



more days), took place in general medicine and four were in general surgical wards, while there were no recorded incidents in accident and emergency departments. There is a problem of under-reporting in accident and emergency (see paragraph 1.33). North Glamorgan NHS Trust told us that low levels of physical violence at accident and emergency departments, in comparison to ward level, are often due to early risk assessments of potentially violent and aggressive situations followed by appropriate interventions to defuse situations, with security officers present. Once at ward level, the patient may then become agitated; in the most difficult cases this can be due to the effects of, and withdrawal from, substance misuse.

A nurse went to assist another nurse who was being choked by an aggressive and confused male patient. He struck out knocking her glasses off and hitting her in the mouth.

Source: Reported incident in the medical directorate of a Welsh NHS Trust

A male patient became very aggressive, confronting staff and throwing objects at them including a fire extinguisher. Staff received no injuries but the patient had to be sedated to calm him down.

Source: Reported incident in the medical directorate of a Welsh NHS Trust

1.20 Problems arise in medical wards for many different reasons. Some problems are due to a person's condition. For example, when someone with diabetes develops hypoglycaemia they may become confused and agitated, while people recovering from anaesthesia may inadvertently lash out. There are particular problems with elderly patients with dementia, who can cause severe disruption to a medical ward as they may scratch or bite because they are in a confused state; the unfamiliar surroundings of an acute hospital ward can exacerbate this. All physical

symptoms need to be investigated before a patient exhibiting disturbed behaviour is either transferred to a more suitable environment or discharged. However, delays in finding nursing home places for patients with disturbed behaviour means that many patients are on medical wards when they should be cared for elsewhere. As well as representing a poor use of resources, such an inappropriate care environment may also increase the risk of violence and aggression from patients delayed in this way.

A nurse was assisting a female patient into bed when the patient became aggressive, pinching the nurse's arm and causing bruising.

Source: Reported incident in the medical directorate of a Welsh NHS Trust

There are high levels of incidents in learning disabilities services although they are rarely premeditated

1.21 There is a high level of violence in learning disabilities services. **Figure 8** shows that 11 per cent of all recorded incidents took place in learning disabilities services, while **Figure 9** shows that 11 RIDDOR incidents in 2003-04 took place in learning disabilities. Violent incidents by this client group are rarely premeditated and there is no evidence of problems with relatives. Appendix 2 shows a particularly high incidence in Bro Morgannwg NHS Trust, which provides learning disabilities services across five South Wales Trust areas including Cardiff and Swansea. The Trust is well aware of the level of incidence and informed us that the large increase in numbers in 2002-03 was due to increased reporting as well as the disruption caused by the closure of Hensol Hospital and the relocation of patients to a number of new units. These new units have been designed to provide a much better

environment for care and should result in a reduction in incidents. The Trust also provides specialist care for people with behavioural problems – many reported incidents occur within this client group.

A staff nurse, working with people with learning disabilities, was restraining a patient in a seated position when the patient attempted to head-butt him. In the process of trying to avoid the head-butt, the nurse suffered a shoulder injury.

Source: Welsh Health Legal Services

Community and women's services face particular risks of violence as they employ high numbers of staff who work alone

1.22 Figure 8 shows that community services accounted for ten per cent of reported incidents in 2003-04, while obstetrics and gynaecology accounted for a further one per cent. None of the RIDDOR incidents in 2003-04 took place in these areas (Figure 9). Community and women's services cover a wide range of services available in people's homes or in community clinics. The staff mix includes district nurses, health visitors, midwives, family planning service staff, school nurses and clinical nurse specialists. They often work with the same patients over a long period of time, and frequently go to someone's home as a lone worker. Staff, working alone in a patient's home, have little control over their environment and may find it difficult to get assistance if an incident occurs. Incidents may be caused by relatives, particularly if staff are present when the patient is involved in a domestic violence situation. Health visitors sometimes work with children on the 'at risk register', which increases the risk of violent incidents.

A youth tried to steal a district nurse's bag in the street and she was dragged to the ground. The youth ran off when members of the public came to her assistance.

Source: Reported incident in the community directorate of a Welsh NHS Trust

On a home visit, a patient was threatening his mother with a knife. The district nurse got involved and was able to defuse the situation and stop it from escalating.

Source: Reported incident in the community directorate of a Welsh NHS Trust

Ambulance service staff have particular issues with offenders who are intoxicated

1.23 Figure 8 shows that the Welsh Ambulance Services NHS Trust accounted for two per cent of all incidents reported in Wales, while Figure 9 shows that it had five RIDDOR incidents in 2003-04. Ambulance personnel frequently attend calls with limited information about the location and are called to incidents where violence may already be occurring. The Welsh Ambulance Services NHS Trust has analysed the causes of incidents in the South East Wales region. Whilst the inside of the ambulance used to be the most frequent setting where incidents occurred, this changed in 2004 to the patient's house. They also found that people under the influence of alcohol and/or drugs caused 88 per cent of incidents of violence and aggression in 2003-04, while the other 12 per cent arose from the person's medical condition. Forty-four per cent of all incidents resulted in injury to the staff member; twelve incidents involved the use of, or threats with, a weapon such as a knife whilst others involved fists or feet. They found that a small number of repeat offenders cause a disproportionately large number of incidents.



Whilst a paramedic was examining a female patient who had been assaulted, her brother jumped on the back of the ambulance and grabbed the paramedic around the neck. The assailant was restrained and the police arrested the individual.

Source: Incident reported in the Welsh Ambulance Services NHS Trust

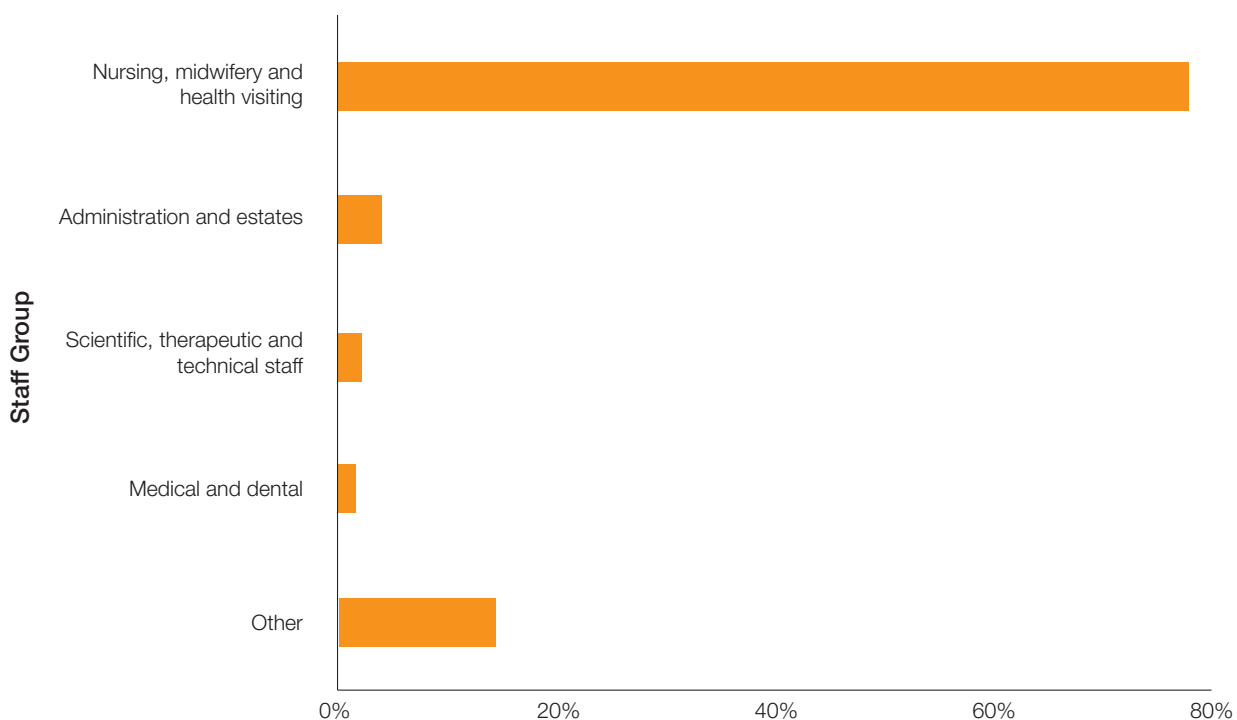
An intoxicated patient was uncooperative whilst being transported to hospital. The patient tried to get up off the stretcher whilst the vehicle was moving and had to be restrained. A paramedic was struck with a glancing blow to the neck. The patient calmed down after the initial outburst but became abusive towards hospital staff on being handed over to accident and emergency.

Source: Incident reported in the Welsh Ambulance Services NHS Trust

Reported numbers of incidents vary by staff group with nurses experiencing the majority of incidents

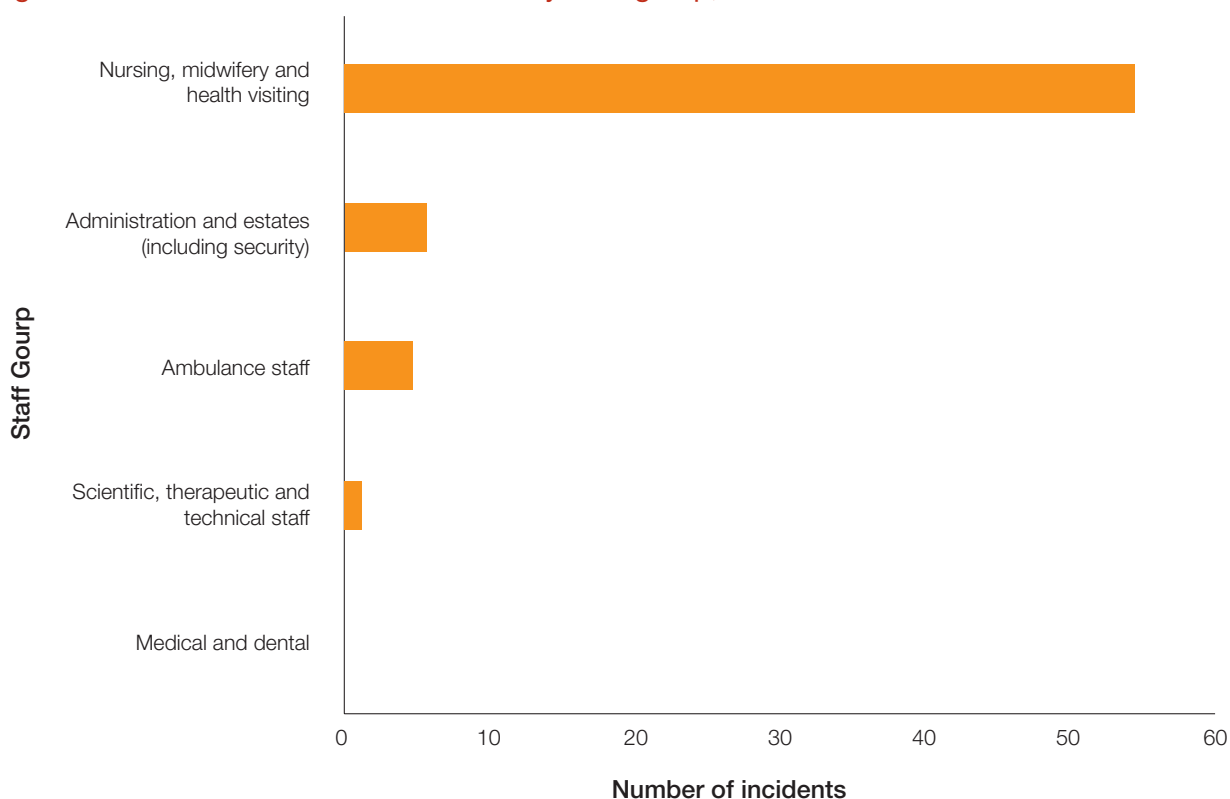
1.24 As well as variation by department and setting, the extent of violence varies by staff group. Eight Trusts were able to supply us with analysis of incidents reported by different staff groups in 2003-04, comprising just over one third of all reported incidents. **Figure 11** shows that 79 per cent of these 2,787 incidents affected nurses, midwives or health visitors (who account for 47 per cent of all Trust staff) while **Figure 12** shows that 54 of the 66 RIDDOR incidents affected nursing staff. Nursing staff are more vulnerable than other staff groups as they provide most contact with patients and can become the focus of aggression when people are in pain or frustrated by having to wait. Relatives may also cause problems for nursing staff when they want to visit at a time that is inconvenient to healthcare requirements.

Figure 11. Percentage of incidents reported by staff group, 2003-04



Note: Data supplied by eight Trusts and relate to a third of all reported incidents
Source: Wales Audit Office survey of all NHS Trusts and Powys Local Health Board

Figure 12. Number of RIDDOR incidents by staff group, 2003-04



Source: Wales Audit Office survey of all NHS Trusts and Powys Local Health Board

Violence and aggression has a range of costs to staff and the NHS in Wales

1.25 The NHS is the largest employer in Wales with over 87,000 staff employed by NHS Trusts, making up more than seven per cent of the Welsh workforce. NHS Trusts spent over £1.8 billion on salaries and wages in 2003-04 which represents 67 per cent of total expenditure by NHS Trusts on health services in Wales. The Auditor General for Wales’ report, *The management of sickness absence* by NHS Trusts, found that general staff sickness absence cost the NHS in Wales £66 million in 2002-03. NHS Trusts do not routinely hold information on the extent of absence due to individual acts of violence or from stress arising from working in an environment where the risk of violence is high.

1.26 The Welsh Risk Pool requires Trusts to record the number of working days lost due to violence and aggression. We asked Trusts if they could tell us how many staff were on sick leave due to incidents of violence and aggression. Other than Velindre NHS Trust, no Trusts could provide information on sick leave arising from violence and aggression because they did not code sickness absence arising from violence and aggression. RIDDOR reporting means that Trusts should know who is off for three days or longer; however, RIDDOR does not account for those who are absent through stress that may have been induced by one or more violent incidents. Trusts should also know who is away from work for less than three days as a result of violence and aggression. A group from the Welsh Risk Managers' Network has been set up to look at serious incidents and how Trusts classify



incidents for analysis. Furthermore, the development, and implementation in all NHS Trusts, of the Welsh Assembly Government Electronic Staff Record should improve the recording of staff absence due to work-related incidents although there is currently no plan to differentiate violence and aggression from other causes of sickness absences.

1.27 Whilst eight Trusts told us that violence and aggression did not have any impact on recruitment and retention anywhere in their Trusts, seven Trusts said there were problems in particular areas, namely, mental health, medical admissions and accident and emergency. However, they were unable to quantify the number of staff who had left due to violence, nor the cost of replacing them.

1.28 The impact of violence on staff is manifold and imposes a number of different costs on individuals and NHS Wales. The Comptroller and Auditor General in his 2003 report *A safer place*

to work: protecting NHS hospital and ambulance staff from violence and aggression estimated that violence cost the NHS in England £69 million in 2001-02 which included the cost of sickness absence, NHS Trust liabilities, and compensation, benefits and ill-health retirements for injured staff. The calculations exclude the cost of temporary and permanent replacement staff, training costs and counselling services, and made no attempt to calculate the costs to the individual, including physical pain, stress (particularly if an incident goes to court), loss of confidence, and psychological problems.

Figure 13 provides an estimate of some of the direct costs to NHS Trusts in Wales of violent incidents which in 2003-04 amounted to some £6.3 million for staff replacement due to RIDDOR incidents, legal costs, training and security. These costs do not include recruitment and retention of replacement staff, early retirement, cost of replacing staff on training courses, damage to equipment, environmental modifications or human costs.

Figure 13. Cost of violence and aggression in NHS Trusts in 2003-04

Description	Calculation	Cost (£ million)
Staff replacement costs ¹	RIDDOR incidents (based on average levels of sickness absence)	0.4
Training costs ²	External and internal training events (excluding staff replacement costs)	0.9
Legal costs ³	60 cases (at average cost of £33,000)	2.0
Security ⁴	Employing staff for all aspects of security	3.0
Total		6.3

Sources: 1 and 2. Wales Audit Office survey data, 3. estimate from Welsh Health Legal Services, and 4. Welsh Health Estates' Facilities Performance Report 2003-04.

1.29 Violence and aggression at work can contribute to stress, anxiety and depression; consequently, it represents a potential barrier to the effective provision of healthcare services because of its impact on staff attendance, as well as recruitment and retention of key clinical staff. The Health and Safety Executive found that nurses have three times the national average rates of stress, depression or anxiety (an estimated rate of 2.2 per cent compared to the average of 0.7 per cent). Furthermore, a recent study in England by the University of Nottingham said that nurses, who bottled up anger triggered by a violent incident at work, are more likely to become nervous, worn out and depressed. The Health and Safety Executive campaign, *Revitalising Health and Safety*, covers work-related stress. The Health and Safety Executive has concluded that levels of stress across the United Kingdom workforce have risen but that the steep rises of the first few years since 1999 have levelled off. The Health and Safety Executive issued stress management standards in November 2004 and has started work on a ‘buddy’ scheme where an inspector can help to facilitate various ways to reduce work related stress in organisations. Two NHS Trusts in Wales will participate, along with other organisations from the wider public sector. Stress is a key health and safety issue and is the leading cause of work-related sickness absence. Employers therefore need to do all that is reasonably practicable to reduce this risk.

The statistics are incomplete because Trusts use different definitions and there is under-reporting

The accuracy of the data is compromised by the different definitions in use

1.30 There are a number of different definitions in use for violence at work within NHS Trusts. Six NHS Trusts told us that they use the Health

and Safety Executive’s definition, while another six use the definition from the Department of Health’s zero tolerance zone campaign; both definitions are very similar in scope. North West Wales NHS Trust uses a longer definition that includes some of the causes of violence while the Welsh Ambulance Services NHS Trust uses a definition that includes the types of people who may be perpetrating violence and aggression as well as a further definition of verbal abuse. Of these thirteen NHS Trusts, nine have clarified that verbal abuse is included. The two Trusts solely using other definitions, Conwy and Denbighshire and North East Wales, use definitions from different sources and are the only Trusts to say that their definitions only include serious incidents. Appendix 6 lists all the definitions in use across NHS Trusts in Wales.

There is under-reporting of incidents of violence and aggression

1.31 It is important that less significant acts of violence are recorded as they may be precursors to more serious incidents and regular verbal abuse may cause long-term stress for staff. Welsh Risk Management Standard 3 (see paragraphs 2.10 to 2.12) on incident and hazard reporting states that Trusts should have a set of organisation-wide indicators of the specific patient and non-patient incidents and near misses which should always be reported and monitored. ‘Disruptive, aggressive behaviour (physical or verbal)’ is one of the twelve main indicators.

1.32 NHS Trusts in Wales told us that there has been a significant increase in staff awareness that they should report all incidents of violence and aggression because they regularly emphasise its importance in induction programmes and violence training. Welsh Risk Management Standard 3 states that Trusts should “promote a



positive and non-punitive approach towards incident reporting”. All Trusts thought that staff would report serious incidents, especially if there was an injury.

1.33 However, there are still areas where staff do not report; some incidents have only come to light during training sessions or in discussions with security staff. The comparatively low levels of reported violence in accident and emergency do not mean that violence and aggression is not a problem in this area. Appendix 2 shows that in two Trusts incidents have not been separately analysed or have been included with the figures for general surgical wards. Other evidence suggests that there are problems in accident and emergency at some Trusts in Wales; nine Trusts reported that they called the police every week to deal with violence and aggression in accident and emergency, much more frequently than to other areas of the hospital. Interview evidence suggested that the fast pace of accident and emergency work means that staff have less time to report incidents, and that they have high levels of tolerance of verbal abuse because of the nature of accident and emergency work.

1.34 Figure 11 show that medical and dental staff accounted for just one per cent of all reported incidents. However, this contradicts a recent survey of hospital doctors and GPs by the British Medical Association, which found that one third of hospital doctors responding to the survey said that they had experienced some form of violence in the workplace during the previous year, although only a third of them had reported the incident. Hospital doctors experienced the highest rates of violence at work in accident and emergency (73 per cent of doctors working in this department reported experiencing violence and aggression),

psychiatry (56 per cent) and obstetrics and gynaecology (50 per cent). This suggests that under-reporting by doctors remains a major issue for NHS Trusts in Wales.

1.35 It is important that staff report as many incidents as possible since this management information should drive Trusts to take positive action to improve staff safety. The reasons given to us by staff for not reporting include:

- the incident report forms take too long to fill in;
- professional pride;
- there is no point as nothing will change; and
- that some staff accept a certain level of abuse as part of the job.



Part 2: Although the Welsh Assembly Government and NHS Trusts have generally taken steps to prevent incidents of violence and aggression, there remains scope for further improvement

2.1 Although NHS Trusts, as employers, have the primary responsibility for managing the risk of violence and aggression, the Welsh Assembly Government is responsible for setting the overall policy and performance management framework in which Trusts operate. This part of the report considers the actions of the organisations responsible for protecting staff from violence and aggression (see Figure 14) and what is done by them after incidents occur.

Figure 14. Organisations responsible for protecting staff from violence and aggression in Wales

- a** The Welsh Assembly Government sets the policy framework;
- b** NHS Trusts are the employers of the majority of NHS staff;
- c** the Health and Safety Executive enforces health and safety legislation and regulations;
- d** the Welsh Risk Pool assists NHS Trusts in developing effective risk management systems and oversees the Welsh Risk Management Standards, with which NHS bodies are expected to comply to improve safety for staff, patients and visitors;
- e** the police respond to calls for assistance during incidents of violence and aggression, arrest perpetrators and investigate incidents and they also work with Trusts in a number of other ways (see Figure 22); and
- f** the Crown Prosecution Service decides whether to pursue a prosecution.

The Welsh Assembly Government has generally taken positive steps to address violence and aggression

The Welsh Assembly Government has clarified policy through Welsh Health Circulars

2.2 In February 1999, the Welsh Office issued a circular *Prevention of Violence in the NHS* to all NHS Trusts in Wales. In it, NHS Trusts were asked to take steps to reduce violence against staff, set targets for reducing violence both on Trust premises and in the community and contribute to the reduction of violent crime in the wider community through a partnership approach with the police and prosecution services.

2.3 Subsequently, the Welsh Assembly Government stated in its NHS Plan of 2001 that “violence and the threat of violence against staff must be eradicated”, and issued a follow up circular in January 2002 recommending that NHS Trusts follow the zero tolerance zone campaign that was launched in England three years earlier in 1999 (see Figure 15). The circular stated that reducing violence against NHS staff must become a high priority and that each NHS Trust should consider how best to incorporate the key messages of zero tolerance into their existing policies. Trusts were also reminded that they should have set targets to reduce violent incidents following the circular from 1999 and that they should report to staff organisations on progress. At the same time, Trusts were to encourage staff to report all incidents of violence and aggression. A further Welsh Health Circular, which accompanied the All Wales Staff Opinion Survey in 2004, stated

Source: Wales Audit Office



that Trusts should regularly review policies, procedures and guidance, and that an all-Wales approach to violence and intimidation may be set up eventually.

Figure 15. NHS zero tolerance zone campaign

The NHS zero tolerance zone campaign was launched in England in October 1999 with the support of the Home Secretary, the Lord Chancellor and the Attorney General. It aimed to increase staff awareness of the need to report violent incidents, assure staff that this issue would be tackled and inform the public that violence against staff working in the NHS is unacceptable. A web site provides detailed guidance for NHS Trust managers on developing policies and procedures to tackle violence.

Source: Department of Health

2.4 Since its creation in 2003, the Counter Fraud and Security Management Service (see Figure 16) has received additional funding to set up training in all Trusts in England and to set up a reporting system for serious incidents of violence. The Welsh Assembly Government decided not to contract into the Security Management Service services as structured in England because the Welsh Assembly Government was developing its own policy on training (paragraphs 2.6 and 2.7), and is now developing its own serious incident reporting system.

Figure 16. The Counter Fraud and Security Management Service

The Counter Fraud and Security Management Service is a Special Health Authority which has responsibility for all policy and operational matters relating to the prevention, detection and investigation of fraud and corruption and the management of security in the National Health Service in England.

The creation of the Service on 1st January 2003 brought together the NHS Counter Fraud Service (with the remit of tackling all losses to fraud and corruption in the NHS) and a new Security Management Service. The Counter Fraud Service has a remit across the NHS in England and Wales, while the Security Management Service covers England only.

Initiatives from the Counter Fraud and Security Management Service in England include:

- the requirement of a nominated NHS Trust executive director to lead on violence against staff;
- the implementation of a new national incident reporting system for recording physical violence;
- investigation of cases of physical assault; and
- the development and delivery of a national syllabus for conflict resolution training (excluding physical intervention training) across the whole of the NHS in England.

Source: NHS Counter Fraud and Security Management Service

2.5 In contrast with England, policies to tackle violence and aggression in the NHS in Wales have not attracted any additional funding because the Welsh Assembly Government sees health and safety management as part of Trusts' general responsibilities as employers, which are funded through Trusts' core allocation. The Comptroller and Auditor General's report, *A safer place to work - protecting NHS hospital and ambulance staff from violence and aggression*, showed that in England, over the three years from 2001, Trusts received £1.5 million funding to support local initiatives to tackle violence against staff. Some Trusts in Wales expressed concern that the lack of any extra funding from the Welsh Assembly Government acted as a barrier to implementation of their violence and aggression policies.

By issuing the violence and aggression training 'passport', the Welsh Assembly Government has significantly improved the risk management framework for violence and aggression in the NHS in Wales

2.6 The All Wales Steering Group for the Management of Violence and Aggression was set up in 2001, as a sub group of the Welsh Health Trusts' Health and Safety Advisors' Forum, to support Trusts in tackling violence. The membership of the group comprised health and safety staff in NHS Trusts, the Health and Safety Executive, and staff representative organisations, as well as Welsh Assembly Government officials in an ex officio capacity. This group discussed the implementation of violence policies in Trusts across Wales and developed strategies for dealing with legal issues, risk assessments, lone working, and training. The work of the steering group culminated in September 2004 with the launch, by the Deputy Minister for Health and Social Services, of the *All Wales NHS Violence*

and Aggression Training Passport and Information Scheme (the passport) and its publication in March 2005. The Welsh Assembly Government told Trusts that the Health and Safety Executive will consider progress against the passport in its routine audits of Trusts and recommended that Trusts develop action plans to implement the passport by 31 March 2006. The passport provides:

- a** recommendations on a common definition of violence and aggression;
- b** guidance on carrying out risk assessments and developing action plans;
- c** minimum requirements for the first three levels of training namely, induction and awareness raising, personal safety and de-escalation, and breakaway techniques;
- d** a withdrawal of care policy; and
- e** a lone working policy pro-forma and a specification for an electronic lone worker tracking system.

2.7 The development of the passport in Wales provides a framework which has significant potential to improve the management of violence and aggression across the NHS in Wales, and which is different from policies implemented in England and Scotland (see Appendix 5 for details of policy in Scotland). It is called a passport because it will allow all staff who have completed a training course in one NHS Trust to be able to use it if they change jobs to another Trust in Wales, thus reducing duplication and repetition of previous training and assuring Trusts that training meets required standards. Almost all NHS Trusts told us that they thought it was useful to have a consistent



all Wales approach to training, withdrawal of care and lone working, supported by the Welsh Assembly Government and transferable across Trusts. However, Trusts have expressed concern that implementing the passport might result in additional costs, particularly for releasing staff for training and covering their duties. Neither England nor Scotland has implemented such a policy.

The Welsh Assembly Government has abandoned misguided quantitative targets to reduce the number of reported incidents of violence and aggression

2.8 The Welsh Assembly Government manages the performance of NHS Trusts in delivering its policies through the Service and Financial Framework (SaFF), which specifies the targets health communities must achieve within their financial allocations. In the 2002-03 SaFF, the Welsh Assembly Government set a target to reduce, by March 2004, the number of incidents of violence and aggression by 10 per cent from the September 2002 baseline. This target was based on the Health and Safety Executive's *Revitalising Health and Safety* campaign's aim to reduce work related ill-health by ten per cent by 2004. Initially the Welsh Assembly Government target was a 'continuous improvement' target, whereby Trusts would be expected to improve on their current performance but would not necessarily have to achieve the full target immediately. In January 2003, the Welsh Assembly Government issued a Welsh Health Circular which said that the violence and aggression target had "minimum standard" status, whereby it was an absolute standard which Trusts must achieve by March 2004. However, most Trusts had not established a baseline level of violence in September 2002. When Welsh Assembly Government officials tried to establish the level of violence and

aggression in 2002, most Trusts were unable to provide any robust data for comparison.

2.9 Whilst it is essential to try to reduce the levels of violence in NHS Trusts, this quantitative target to reduce the reported levels of violence could have provided a perverse incentive, discouraging Trusts from fully reporting all incidents of violence and aggression. In turn, this may have had the unintended consequence of reducing the quality of management information available and therefore increasing the risk of violence and aggression. For 2004-05 the number of targets within the SaFF has reduced from 104 to 40 and there is no longer a target for violence or health and safety. The new Performance Improvement Framework, based on a Balanced Scorecard, does not mention violence specifically, although it does say that Trusts should aim for compliance with Welsh Risk Management Standards which are discussed in more detail in paragraphs 2.10 to 2.12.

Welsh risk management standards provide a baseline from which to improve Trusts' risk management

2.10 The Welsh Risk Pool exists to assist NHS Trusts and Local Health Boards to develop effective risk management systems, through the application of risk management standards, and the settlement of legal claims. Conwy and Denbighshire NHS Trust manages the Welsh Risk Pool which has produced a total of 40 Welsh Risk Management Standards, with which NHS bodies are expected to comply to improve safety for staff, patients and visitors. The first three standards cover risk management systems, risk profile and adverse incident and hazard reporting. Violence and aggression is not covered by any one standard but is incorporated as part of standards on health and safety management, maternity, accident and

emergency, mental health, community, and security management. The Welsh Risk Management Standard for security has recently been revised and issued with detailed guidance to the NHS in Wales in order to ensure that there is a safe environment and systems in place to protect patients, staff and visitors.

2.11 Every year, NHS Trusts carry out a self assessment against each of the 40 standards, producing action plans that are reviewed by the Welsh Assembly Government. The Welsh Risk Pool also carries out assessments at Trusts on the first 21 standards plus three others. They found that overall risk management was improving across NHS Trusts but that there as a minority of organisations which had failed to meet required risk management standards.

2.12 Trusts told us that, although the Welsh Risk Management Standards are a useful source of evidence for monitoring progress, none of them thought that they were very effective in helping them manage the risk of violence and aggression, because they do not evaluate the efficacy of their policies and training regimes. The Welsh Risk Pool will issue a revised risk management standard 13 for occupational health and safety to tie in with the passport and other developments in health and safety and to ensure Trust action plans to implement the standard are in place. Together with the revised standard on security, this should provide much clearer guidance to NHS Trusts on managing the risk of violence and aggression.

NHS Trusts have improved their management of the risk of violence and aggression, but there remains scope to improve their handling of incidents when they occur, train staff and work with other agencies

Since 2001, five Trusts have complied with improvement notices issued by the Health and Safety Executive in respect of violence and aggression

2.13 The Health and Safety Executive provides extensive guidance to employers on managing health and safety risks. In particular, [Figure 17](#) shows the Health and Safety Executive's five point plan for effective health and safety management.

Figure 17. The five steps to effective health and safety management



Source: Wales Audit Office, based on Health and Safety Executive, *Managing health and safety: Five steps to success*. 1998.



2.14 Based on its guidance and the legislative framework, the Health and Safety Executive has carried out audits of risk management systems for health and safety, including the management of violence and aggression. The Health and Safety Executive selected two NHS Trusts in Wales and 39 in England and Scotland. Using RIDDOR data, it targeted the areas with the most significant problems: accident and emergency departments, elderly care, mental health and community and lone workers including ambulance services. Inspectors assessed and reported back to Trusts on the adequacy of:

- a** risk assessments of violence, carried out by a competent person with the involvement of staff or their representatives; and
- b** a violence and aggression policy, which should be understood by employees, and covers the physical environment, working patterns and practices, staffing levels and competencies, staff training, security and response strategies.

2.15 Between April 2001 and March 2005, inspectors from the Health and Safety Executive visited all NHS Trusts in Wales, other than Velindre. They carried out a routine inspection of violence and aggression policies and procedures at ten Trusts; investigations following serious incidents took place at two Trusts; a visit to serve an improvement notice (see Figure 1) on one Trust, and a visit to follow up progress made since a notice was issued, (before April 2001), occurred at another Trust. The Health and Safety Executive issued improvement notices against four Trusts (Bro Morgannwg, Cardiff and the Vale, North East Wales and Powys) following routine inspection visits and one improvement notice was issued to Swansea NHS Trust following a serious incident. All Trusts subject to Health and Safety Executive improvement notices informed us that the notice

had raised the profile of violence and aggression across the Trust, and all of these Trusts have now complied with the notices following satisfactory remedial action. The improvement notices arose because of:

- a** a lack of violence and aggression policies;
- b** a need to extend the training provision for mental health workers and other staff at risk; and
- c** a failure to carry out suitable risk assessments for lone workers.

NHS Trusts have established clear frameworks to manage the risk of violence and aggression

All Trusts have designated a senior executive with responsibility for the management of violence and aggression and most Trusts discuss it at board level every year

2.16 The Health and Safety Executive and Welsh Risk Management Standards consistently emphasise the importance of senior management commitment and leadership for the effective management of health and safety risks. Consequently, all NHS Trusts have designated a senior member of staff responsible for tackling violence and aggression against staff. At only one Trust was the chief executive responsible, while the head of human resources was the most common choice (six Trusts). The other eight Trusts nominated the head of operational or corporate services, the executive nurse or the deputy chief executive.

2.17 We found that fourteen Trusts discuss violence and aggression at the Trust board at least once a year, of which five discuss violence and aggression on a quarterly basis. Only one Trust – Ceredigion and Mid Wales – told us that it does not discuss violence and aggression at board level at all.

All NHS Trusts have developed violence and aggression policies at various levels

All Trusts have developed corporate policies although not all were current

2.18 We found that, while all Trusts had a violence and aggression policy, not all had been updated since 2001. Trusts should ensure their policy has been reviewed, and revised as necessary, ideally once every three years or when circumstances change, such as with the launch of the passport. All Trusts said that they either provide staff with a hard copy of the policy or tell them it is available on the intranet as part of their induction. In nine Trusts, managers also explained the policy to new starters. Pembrokeshire and Derwen NHS Trust ensured that staff understood their violence and aggression policy by issuing a leaflet to all staff with an explanation of the policy and guidance on what to do if they are involved in an incident. Cardiff and Vale NHS Trust has developed a staff charter. Its first aim is to provide a safe, secure and supportive environment in which violence and abuse is not tolerated from any source, and that systems, policies and procedures are in place to facilitate this. It also contains a patient undertaking procedure to give practical support to staff when dealing with individuals who are violent or abusive.

2.19 Trusts have a statutory duty to involve staff, and their representatives, in the development of health and safety policies. Moreover, staff have the detailed knowledge of the risks they face on a day to day basis. We found that all Trusts consulted staff, through one of the following:

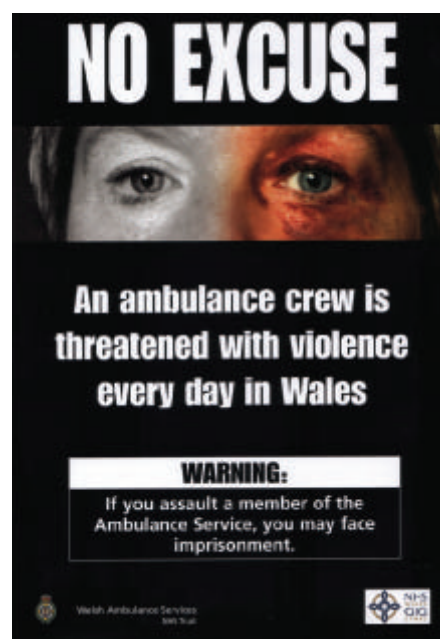
- a** trade unions or staff professional associations;
- b** health and safety committees; or

- c** direct consultation with individual staff.

Five Trusts have set up violence and aggression committees specifically to develop policies and monitor incidents of violence. A further eight Trusts discuss violence at various sub groups of health and safety committees or at divisional level.

High risk directorates have developed their own policies

2.20 Part 1 of this report showed that certain service areas have higher risks of violence and aggression than others. For this reason, it is important for Trusts to develop specific policies addressing risks in these areas. The majority of Trusts in Wales have developed and implemented violence and aggression policies specifically tailored to high-risk areas. All Trusts providing mental health and community services have developed their own policies, while some Trusts have developed violence and aggression policies for other directorates such as estates and facilities.



Source: Welsh Ambulance Services poster campaign



Figure 18 describes a range of policies and initiatives that have been developed by NHS Trusts for high-risk departments.

Figure 18. Examples of violence and aggression policies and initiatives

Accident and emergency services: Swansea NHS Trust opened a new accident and emergency unit in Morriston in August 2003; staff were involved in designing it, paying particular attention to reducing violence. Some of the techniques that they use include providing regular updates to patients about how long they will have to wait, having furniture that cannot be moved, televisions, drinks machines, and a dedicated police room. A poster is prominently displayed at the entrance advising patients that they should treat staff with respect or they could be refused treatment. Another innovation at Swansea was the award-winning 'field hospital' run by the Welsh Ambulance Services NHS Trust in Swansea city centre over key dates of Christmas and New Year in 2003 which helped to reduce the number of people attending accident and emergency departments, thus reducing the risk of violence.

Trauma ward: Ward staff at some Trusts told us that they would like to be able to call a psychiatrist or psychiatric nurse to assess patients exhibiting problematic behaviour on acute medical or surgical wards but that psychiatric staff were not always available to come to the wards. The specialist burns and plastics ward at Morriston Hospital has employed a psychiatric nurse on the ward to assess patients and help with the de-escalation of incidents as many of their clients misuse drugs and alcohol and/or have mental health problems. Ward staff have found that this arrangement works well and is better than calling for security

staff who do not have the specialist skills to work successfully with this group of clients.

Cardiac ward: There is a risk of violence with a condition known as post-pump psychosis which has been found to affect a small number of people in the first few days after cardiac surgery. The Cardiac High Dependency Unit at Morriston Hospital provides awareness, talk down and breakaway training to staff to help them to understand these particular risks and what to do in the event of an incident.

Community services: Trust staff working with people in their own homes carry out risk assessments when they visit for the first time, looking at the environment and any other risks they may encounter, such as dogs and poor lighting. In the case of poor lighting, a district nurse at Pontypridd and Rhondda NHS Trust worked with the council to have an outside light fitted above the front door as she would be visiting through the winter evenings.

Ambulance services: The Welsh Ambulance Services NHS Trust is aware that, despite encouragement, staff do not report all incidents as they see a certain level of violence and aggression as part of the job. The Trust ran a public campaign with posters in accident and emergency departments, GP surgeries, pubs and clubs saying that violence against staff is not acceptable. Welsh Ambulance Services NHS Trust issued all staff with a booklet *Personal safety and management of conflict: a guide to staff*, which provides advice on techniques to help de-escalate potentially violent incidents and steps to take in the event of an incident occurring.

Source: Wales Audit Office visits to NHS Trusts

2.21 Mental health and learning disabilities services have high levels of violent incidents and worked with the Royal College of Psychiatrists on an audit of violence and aggression in residential settings (Figure 19). A final report, consisting of aggregated findings and examples of good practice, was published in May 2005.

Figure 19. Managing violence and aggression in mental health and learning disabilities residential services

A major review of violence in mental health settings in England and Wales was carried out by the Royal College of Psychiatrists' College Research Unit in conjunction with the Healthcare Commission. The programme ran from December 2003 to March 2005 and collected data from staff, service users and visitors to help Trusts to understand the problems they face in acute wards and community-based settings and worked with them to implement improvements based on local findings. Five NHS Trusts took part in Wales in the mental health setting, while one of them also participated in the learning disabilities setting.

Source: Royal College of Psychiatrists' College Research Unit in conjunction with the Healthcare Commission, The National Audit of Violence (2003-2005): final report. May 2005.

Trusts have developed lone worker policies but not all are adequate

2.22 The provision of healthcare services often involves clinicians visiting patients in their own homes, or peripatetic health professionals moving between locations in the community. For some staff groups, lone working can be a routine aspect of their daily work. The Health and Safety Executive defines lone working as

“those who work by themselves without close or direct supervision”. Peripatetic staff, working alone in community clinics and patients' homes, face a particular risk from violence as they may encounter difficulties in getting assistance in the event of an incident. Particular issues arise for lone workers when they visit a property for the first time to assess a new patient as they will have only limited information about them. Consequently, the development of policies for lone workers is essential. We found that all Trusts had a lone worker policy.

2.23 Our visits to Trusts found that the relevant staff were aware of lone worker policies and complied with most elements of those policies. For example, many community staff would go alone to patients' houses to carry out risk assessments on the first visit; this assessment covers all aspects of health and safety risk, not just the risk of violence and aggression. However, if there was any suspicion that there was a risk of violence, from either the patient or someone they lived with, then staff would attend in pairs. If there was further concern, the patient would be asked to attend the clinic and staff would cease to make regular home visits.

2.24 Effective monitoring of the personal safety of lone workers depends largely on systems to log them in and out at the end of each working day. We found that such logging systems were of variable quality and were often set up differently in each department of a particular Trust. Some Trusts had a receptionist who kept a diary of the whereabouts of peripatetic staff, who then had to make contact by telephone to confirm where they were going. Some community staff told us that they thought this system was not sufficient, especially as mobile phones were not made available to all staff. We also found that some Trusts expected the family of staff to monitor



their whereabouts, particularly at the end of the day even though some staff live alone. However, Bro Morgannwg NHS Trust has provided mobile phones for all community staff and is piloting an automatic logging system. In addition, some Trusts have already invested in lone worker alert systems – a technological solution to ensure that staff have arrived and departed safely from a particular visit – while others have not invested in technology as they are waiting for the Welsh Assembly Government to provide a system for use across Wales.

2.25 The violence and aggression passport includes a pro-forma lone worker policy; guidance on risk management and assessment for lone workers; and a specification for use when procuring a lone worker alert system. This will help Trusts to grip the issue of protection for staff who work alone and are therefore particularly at risk of violence and aggression. The Welsh Assembly Government is investigating the best system to use for an all-Wales alert system.

Trusts have taken a range of measures to prevent violent incidents from happening in the first place

Risk assessments are being carried out by all Trusts but not every year

2.26 The proactive assessment of the risk of violence and aggression, supported by appropriate action to minimise that risk, is the basis for the effective management of violence and aggression, as well as compliance with health and safety legislation. All Trusts had carried out risk assessments in each key area at least once since April 2002, or planned to do so in 2004-05. However, Conwy and Denbighshire NHS Trust informed us that they did not carry out generic risk assessments of buildings unless

something was specifically remiss, although they do risk assess all mental health patients on admission. Ten Trusts told us that they had carried out risk assessments in a total of 14 other high risk areas, including specialist treatment centres, radiography, security and administration. The passport provides a pro-forma for Trusts to use as a basis for carrying out their workplace risk assessments.

All Trusts are providing training but have problems releasing staff from their duties to attend courses

2.27 Health and safety legislation requires employers to provide sufficient training to protect their staff from health and safety risks, including violence. Training should make staff aware of personal safety issues and equip them with skills to protect themselves and others from violence and aggression. Different staff groups need appropriate training depending on the level of risk of violence that they could encounter from patients or relatives. For this reason, training needs assessments should be carried out with all staff to decide who needs to receive what training. Training needs assessments and the provision of training must be a continuous process, as techniques need to be refreshed on a regular basis. Training records for each member of staff need to be established, updated and monitored to inform training needs assessments and refresh training as appropriate.

2.28 We found that NHS Trusts currently plan and deliver their training programmes independently of each other. We also found that seven Trusts were carrying out training needs assessments with all staff with a further six Trusts offering training to what they defined as high risk staff groups, such as security staff or administrative staff dealing with complaints. Two Trusts do not

carry out training needs assessments to ascertain which staff should receive what level of training.

2.29 Figure 20 describes the four levels into which training is classified in the passport. The first three levels of training have been defined in the first edition of the passport. The passport did not develop guidelines for level D training at the same time as levels A to C. However, the Welsh Assembly Government did issue further guidance in March 2005, the *Framework for restrictive physical intervention policy and practice*, which provides advice on best practice in the development of policies for prevention, planning and training for all

statutory agencies, including health and social services. The framework does not link in with the passport and does not recommend a particular set of techniques for restrictive physical intervention, although the National Institute for Clinical Excellence (NICE) published guidelines in February 2005 on the short-term management of disturbed (violent) behaviour in inpatient psychiatric settings. The All Wales NHS Steering Group for the Management of Violence and Aggression will debate whether to develop a single training scheme for physical restraint in the future.

Figure 20. Types of training advocated in the violence and aggression passport scheme

Passport module	Type of training	Description
A	Induction and awareness raising	Explains the risk of violence and aggression in the workplace.
B	Personal safety and de-escalation	Provides an understanding of what constitutes a potentially threatening situation, combined with techniques to prevent or defuse it. It also helps staff to understand when they need to leave the situation to protect themselves and others.
C	Breakaway techniques	Designed to help staff to get out of situations where someone has grabbed them.
D	Restrictive physical intervention	Direct physical contact between persons where reasonable force is positively applied against resistance, either to restrict movement or mobility or to disengage from harmful behaviour displayed by an individual. There is currently no recommended training at this level.

Source: Welsh Assembly Government, *All Wales NHS violence and aggression training passport and information scheme, 2004* and the Welsh Assembly Government's *Framework for restrictive physical intervention policy and practice, 2005*.



2.30 We found that all Trusts offer training at the levels described in [Figure 20](#) and that most Welsh Trusts employ one or more members of staff in-house to provide training programmes. Welsh NHS Trusts have spent or committed over £3 million on providing violence and aggression training over the three years to 2004-05, either paying external training providers or salaried trainers to train Trust staff. Pontypridd and Rhondda NHS Trust spent a further £250,000 and Bro Morgannwg NHS Trust spent £128,000 for new training facilities. Trusts also incur costs of several thousands of pounds in ensuring that trainers are up-to-date in first aid techniques and are registered with the appropriate professional body. The £3 million represents only the direct costs of providing violence and aggression training and does not include the cost of participants' time or the cost of replacement staff, both of which can be considerable. All Trusts said that they have problems releasing staff for courses and providing additional staff to cover their duties on the ward to ensure continuity of care. Some staff book courses but subsequently drop out because of problems obtaining cover for their shift, for example because of staff sickness. Some Trusts, such as Pontypridd and Rhondda, have found innovative solutions to the problem of finding cover for staff by running courses on Saturdays. Gwent Healthcare NHS Trust has used another approach to making staff available for training by investing in the development of an online training package on personal safety that will enable staff to complete their personal safety training at a time convenient for them. Online learning can be useful for courses with no physical component in them as physical techniques would need to be taught face to face.

2.31 As well as the importance of monitoring the provision of training to identify and fill gaps in

individual and corporate training needs, it is essential that Trusts evaluate the quality and impact of the training they provide and take remedial action to improve the delivery of training. We found that twelve Trusts had carried out evaluations of their violence and aggression training provision, which resulted in changes to course content. For example, Velindre NHS Trust told us that there had been a reduction in complaints by blood donors following customer care training for staff at the Welsh Blood Service.

2.32 The Health and Safety Executive looks at the quality of training when they inspect NHS Trusts, and the four improvement notices issued to Trusts following routine inspections since April 2001 found that training arrangements for violence and aggression were inadequate either across the Trust or specifically in mental health. The impact of the improvement notices has been considerable – the Health and Safety Executive informed us that the Trusts had all improved their policies and training provision, and some had appointed full time training co-ordinators. In North East Wales NHS Trust, the improvements to training have resulted in a fifty per cent reduction in the amount of time mental health patients are restrained.

There are examples of Trusts making high risk areas safer

2.33 It is not sufficient for Trusts simply to assess risk; they must follow the risk assessment with proportionate action to reduce the likelihood of the risk causing harm. Often such actions carry low or no cost, although sometimes there will be a capital and/or revenue cost. Some Trusts told us that there was sometimes a problem funding initiatives after carrying out a risk assessment. A number of things can be done to make the environment safer through changes to the design and layout of a ward or department.

Where environments are well-designed and maintained, there is often an improved atmosphere, which can reduce tension and consequently the risk of violence. Another factor is good information, particularly signage so that people know where to go and how long they have to wait. Most accident and emergency departments now have signs saying how long the average wait is to see a clinician.

2.34 If an incident occurs or is threatening to escalate, it is important that staff can summon help easily. Trusts provide a number of different alarm systems, of which the most useful are linked to a central system. At Pontypridd and Rhondda NHS Trust there is a system of infra-red attack alarms, situated on walls but also carried by staff, which link through to onsite security staff when activated but which do not set off an alarm bell where the incident is taking place. The Trust also has a CCTV system around the Royal Glamorgan Hospital site that security staff monitor. Security measures extend to the outside areas, such as car parks, where careful use of lighting and CCTV can help reduce the risk of attack, particularly where staff are working overnight and have to make their way across the estate to their transport home. Pembrokeshire and Derwen NHS Trust has reduced this risk and sought to make its staff feel safer by initiating an arrangement whereby porters accompany staff to their cars after dark. They have also cut down bushes to give a clearer view of who is in the vicinity.

The quality of Trusts' responses to incidents is variable

2.35 Although Trusts should do all that they reasonably can to prevent incidents of violence and aggression from occurring, they cannot eradicate violence and aggression in all

healthcare settings. Trusts must have robust procedures in place to deal with incidents when they occur, to support members of staff affected by violence and aggression, and to take corrective action to learn from any incident.

Not all Trusts had security staff available to help when an incident occurs

2.36 Research undertaken by Community Health Councils and reported by Welsh Health Estates in *The NHS Estate in Wales: Facilities performance report 2003-04* found "that patients look for, and are comforted by, the visible presence of security guards within the hospital grounds ... (as it) does give staff and patients a greater sense of security and deters the opportunistic thief and violent offender". Acute hospital services make use of security staff to deter violence and to help when a violent incident occurs. This is not the case in mental health or learning disabilities as managing patients with disturbed behaviour is an integral part of health care workers' role. We found that nine of the twelve Trusts with an accident and emergency department employed security staff; four said that they were very effective while a further four told us they were somewhat effective. One thought they were not effective. Of the three Trusts without security staff, one told us that they wanted to have security staff available to help with incidents in accident and emergency but the Trust could not afford to employ them.

2.37 Welsh Health Estates estimate that the cost of Trusts employing security staff was £3 million in 2003-04. The Welsh Risk Management Standard on security recognises the importance of training security staff to deal effectively with incidents of violence and aggression to minimise any harmful impact; it requires Trusts to train



security staff in various techniques to handle effectively situations of violence and aggression. In 2003, the Audit Commission's Acute Hospital Portfolio on Facilities Management found that, in Wales, six Trusts had trained all their security staff in dealing with violence and aggression from patients and visitors; two Trusts had trained some of their security staff; and two Trusts had not trained any of their security staff.

Post incident support and counselling is available for staff at all Trusts

2.38 Trusts need to provide appropriate support to staff who experience violence and aggression. After an incident has occurred, all Trusts encourage staff to complete a generic health and safety incident form. **Figure 21** shows that all Trusts sometimes offer counselling, a referral to occupational health and a follow up meeting with a manager, but that less than half of Trusts always offer these support services to staff.

2.39 A violent incident can be extremely traumatic for healthcare staff, particularly given their caring vocation and the corresponding damage an incident of violence against them may cause to their professional pride. Whilst in many cases support from colleagues can help to deal with the feelings which arise from the incident, independent personal counselling should also be available for the victims of violence. Trusts frequently contract in counselling services from providers who are independent of the occupational health department and NHS Trust. An example of this is the confidential free service offered to Welsh Ambulance Services NHS Trust staff by the Network of Staff Supporters Ltd. In North Glamorgan NHS Trust, the local victim support service provides counselling in addition to the counselling services provided by the trust.

Trusts have achieved mixed results from work with other agencies to protect the victims and tackle the perpetrators of violence and aggression

There have been mixed results from Trusts' work with the police

2.40 Nine Trusts with an accident and emergency department call the police to assist with violent incidents at least once a week. The next areas most likely to call for assistance from the police are general medical wards, with six Trusts saying

Figure 21. Post-incident support offered to staff at NHS Trusts

	Always	Often	Sometimes	Never
Counselling	4	5	6	0
Occupational health	4	5	6	0
Follow up meeting with manager	6	8	1	0

Source: Wales Audit Office survey of all NHS Trusts and Powys Local Health Board

that they call the police once a month or more. Other departments in acute hospitals also called the police but less frequently. Eight Trusts said that they called the police to obstetrics and gynaecology departments and that at three Trusts this occurred once a month or more. The Welsh Ambulance Services NHS Trust did not supply any figures but told us that they regularly call for police escorts on calls. The importance of police support in dealing with, and preventing, violent incidents means that NHS Trusts need to develop good partnerships with the police in their area.

2.41 Our survey found that five Trusts were fairly or very happy with the police response. However, two found the police response fairly unsatisfactory, while two said it was very unsatisfactory. Trust staff told us that the reasons they were unhappy with police interventions were that the police did not turn up sufficiently quickly when called to an incident; the intervention used by the police was not appropriate for the situation; or the police left before the situation had been fully resolved. **Figure 22** shows some examples of Trusts engaging with the police to tackle violence and aggression.

Figure 22. Examples of how NHS Trusts are working with the police

Police officers based on hospital sites: North West Wales NHS Trust has had a full time police officer based at Ysbyty Gwynedd for a number of years; Conwy and Denbighshire NHS Trust has arranged for one police officer to have half his beat based at Ysbyty Glan Clwyd and the other half in the local area where he is still available if staff at the hospital need assistance; and Pembrokeshire and Derwen NHS Trust, at two police officers visit Worthybush Hospital as part of

their beat and they have piloted monthly ‘surgeries’ whereby a police officer is stationed in an office in the hospital for a set time to discuss any concerns that staff may have.

Working with other agencies: Staff at North Glamorgan NHS Trust work with the police as part of a multi agency group with a sub group to address issues concerning high risk areas, such as in mental health. The police regularly deliver community safety awareness road shows at Trust premises providing advice and support to staff and the public.

Involvement of the police in the design of premises: At Swansea NHS Trust, police officers helped to design the new accident and emergency department at Morriston Hospital. Accident and emergency staff there told us that they considered employing a police officer but for a number of reasons other measures were put in place, including increased numbers of security personnel, panic alarms and a direct phone link to the local police.

Source: Wales Audit Office survey of all NHS Trusts and Powys Local Health Board

Trusts use various methods to protect staff against repeat offenders

2.42 There is very little risk of violence and aggression from the majority of patients and relatives. However, a very small number of patients and visitors can cause a large number of incidents; (see paragraph 1.10) in addition, there may be someone who has been responsible for one incident but there is a high risk of them causing more problems if they come into contact with NHS staff on another occasion. In such situations, Trusts need to take measures to



protect their employees from this known person. It may be necessary for the Trust to send a warning letter telling the perpetrator that they may have treatment withdrawn or be excluded from Trust premises if their violent or aggressive behaviour persists. Figure 23 shows that six Trusts have never sent any type of letter to perpetrators after an incident had occurred, while two Trusts said that they had a charter of care in place and another one was setting one up. Trust staff consistently told us that that they wanted help developing letters and were concerned about the legal implications of denying people care.

2.43 Some Trusts said that they put warning stickers on the notes of patients who are known to be prone to violence and aggression. North Glamorgan NHS Trust said that it has introduced a scheme called 'Mark your card' to support risk assessment and quickly identify to staff any repeat offenders through the patient record. However, all Trusts implementing such schemes had concerns that this could contravene the Data Protection Act and Human Rights Act and so they were looking to the Welsh Assembly Government for guidance on how best to provide information to staff on high risk patients. Trusts also highlighted the problem of sharing information between different agencies. Just one Trust said that social services, general practice and other hospitals always provided enough information with eleven saying that more information could be provided by all agencies.

Figure 23. Types of letters used by Trusts against perpetrators of violence

	Sometimes	Rarely	Never
Warning letter from department	5	4	6
Warning letter from chief executive	3	1	11
Withdrawal of treatment letter	0	7	8
Solicitor's letter	0	4	11

Source: Wales Audit Office survey of all NHS Trusts and Powys Local Health Board

2.44 All NHS Trusts have a statutory duty to co-operate with Multi-Agency Public Protection Arrangements (MAPPA) under the Criminal Justice Act 2003. These arrangements were introduced in 2001 to enable police and probation to work together to reduce the risk to the general public from re-offending by those being released from prison after serving sentences for sexual or violent offences. A number of Trusts told us that their staff participate in Multi-Agency Risk Assessment Conferences (MARAC), when it is appropriate to do so, and some of these conferences involve people who have been violent in Trust settings.

2.45 Many Trusts were concerned that they did not have the tools to deal effectively with persistent offenders. The All Wales NHS Violence and Aggression Training Passport and Information Scheme provides guidance to Trusts on a number of different approaches that they can take to warn persistent offenders that violent behaviour is not acceptable. It contains a patient undertaking, whereby the rights and responsibilities are set out and needs to be signed by both the patient and a member of staff, an exclusion procedure checklist, and draft letters to patients warning them that they could be excluded or that they have been excluded from Trust premises. This policy has been developed with assistance from the police and solicitors and should provide the support that Trusts have been looking for.

Securing prosecutions against offenders is difficult

2.46 Prosecutions by staff against the perpetrators of violence are important for a number of reasons:

a it tells the perpetrator and the wider public that violence against NHS staff is taken seriously and will not be tolerated;

b if the perpetrator was charged then this would go on their record, which would help staff when carrying out risk assessments and would reduce the risk of someone coming to the hospital with a history of violence but no record; and

c a member of staff can only apply for compensation if the incident has been reported to the police.

2.47 Trust staff told us that it is difficult to obtain prosecutions against the perpetrators of violence because the victim has to take a personal case against the perpetrator, which can be disturbing and time-consuming, as well as leaving staff feeling exposed and vulnerable. In order to help staff to pursue a case at North Glamorgan NHS Trust, the local victim support group can provide witness advice and support at court and the Trust said that the police always investigate incidents of violence when someone is injured.

2.48 We found that five Trusts have prosecuted offenders. To increase the number of successful prosecutions, some Trusts told us that they have developed protocols with the police and Crown Prosecution Service. For example, Pembrokeshire and Derwen NHS Trust has signed an agreement with Dyfed Powys police and the Crown Prosecution Service, agreeing that an attack on an NHS staff member within acute or community services will be treated as seriously as an attack on a member of the police. However, when the patient is a user of mental health services the Trust has had incidents where the Crown Prosecution Service has not pursued cases even though the Trust wanted to pursue them. Staff at a number of Trusts said that they would like the Trust to be able to take out prosecutions, rather than the individual, when the Crown Prosecution Service has decided not to pursue the case. In England,



the Counter Fraud and Security Management Service has set up a central Legal Protection Unit to assist Trusts in bringing about a greater number of successful prosecutions.

2.49 However, even if injured staff want to take their case forward, the police or the Crown Prosecution Service may decide that the case is not worth pursuing, particularly if the perpetrator also has mental health problems which affect their mental capacity. To counter this, two NHS Trusts say that they have an agreement with the police to pursue prosecutions of patients with mental health problems who cause major disruption in the Trust, although one Trust said that this still does not help protect NHS staff.

2.50 The Sentencing Guidelines Council, which was established by the Criminal Justice Act 2003, has a remit to issue sentencing guidelines, which courts must take into account. Sentencing guidelines must include criteria for determining the seriousness of the offence. The council issued a guideline on 'seriousness' at the end of 2004 which included 'aggravating factors' applicable when "the offence is committed against those working in the public sector or providing a service to the public". The Violent Crime Reduction Bill is currently progressing through Parliament. The Bill's aim is to provide the police and local communities with powers to tackle guns, knives and alcohol-related violence which may help to alleviate some of the problems with violence and aggression facing NHS staff.

Appendix 1

Scope and methodology

1. This report focuses on all violence, verbal and physical, against all staff in NHS Trusts perpetrated by patients, their friends and relatives. This covers staff in NHS Trusts in acute, community, mental health and learning disabilities services, administration and management and the ambulance service but does not include Local Health Boards or primary care services provided by General Practitioners and their staff. We have included Powys Local Health Board as they also provide acute services and refer to them as one of the NHS Trusts when discussing the results of our survey.
2. Whilst we are aware that violence and aggression exists between some members of staff, we decided against looking at the problem of bullying and harassment by colleagues. We also did not address the problem of patient against patient violence or staff against patient. Each of these issues would require substantial investigation on their own and could merit a separate study at a later date.
3. To obtain the evidence for our examination, we used a number of different sources. We reviewed existing literature on the subject of violence against staff in a range of employment sectors, in the United Kingdom and abroad. We surveyed all NHS Trusts in Wales to gather detailed data on the numbers of incidents and management systems for dealing with the problem. We also interviewed staff at the following NHS Trusts:

- Conwy and Denbighshire;
- Pembrokeshire and Derwen;
- Pontypridd and Rhondda;
- Swansea, and;
- Welsh Ambulance Services.

Other interviews were carried out with staff from:

- Health and Safety Executive;
- Welsh Risk Pool;
- Police;
- Welsh Assembly Government officials;
- the British Medical Association;
- Royal College of Nursing;
- Welsh Health Legal Services;
- NHS staff who are members of Unison;
- Audit Scotland; and
- the Scottish Executive.

We also took advice from Melanie Westlake, formerly chair of the all-Wales violence and aggression steering group, and Alison Terry, National Audit Office, who provided support on the development of the study and draft report.



Appendix 2

Incidents of violence and aggression at NHS Trusts in Wales in 2003-04

NHS Trust	Adult mental health	General medicine	Learning disabilities	Community	Elderly mentally infirm	Accident and emergency	General surgical	Ambulance services	Obstetrics and gynaecology	Other/ Not known	Total
Cardiff and Vale	288	664	N/S	100	195	73	46	N/S	47	270	1,683
Bro Morgannwg	120	96	467	67	125	39	28	N/S	21	245	1,208
Conwy & Denbighshire	470	N/A	11	189	inc	N/A	N/A	N/S	N/A	295	965
Gwent Healthcare	173	74	182	166	148	14	70	N/S	6	49	882
North East Wales	196	107	43	131	53	inc	71	N/S	N/A	37	638
Swansea	82	154	N/S	18	78	103	124	N/S	2	25	586
Pembrokeshire and Derwen	110	26	103	29	45	24	9	N/S	12	11	369
North Glamorgan	32	83	N/S	4	12	99	0	N/S	2	137	369
North West Wales	189	18	inc	36	inc	45	27	N/S	0	3	318
Powys LHB	41	55	51	23	62	N/S	inc	N/S	1	65	298
Pontypridd & Rhondda	89	97	N/S	4	26	7	6	N/S	7	7	243
Welsh Ambulance Services	N/S	N/S	N/S	N/S	N/S	N/S	N/S	179	N/S	0	179
Ceredigion & Mid Wales	N/S	41	N/S	8	12	26	6	N/S	1	6	100
Cardiganshire	N/S	12	N/S	1	N/S	41	12	N/S	0	28	94
Velindre	N/S	N/S	N/S	N/S	N/S	N/S	N/S	N/S	N/S	39	39
Total	1,790	1,427	857	776	756	471	399	179	99	1,217	7,971
Percentages	22%	18%	11%	10%	9%	6%	5%	2%	1%	15%	100%

Notes: N/S service is not provided by that NHS Trust N/A data is not available Inc data for that category has been incorporated into another category
 Source: Wales Audit Office survey of NHS Trusts in Wales and Powys Local Health Board

Appendix 3

Amount spent on violence and aggression training in NHS Trusts in Wales

NHS Trust	2002-03	2003-04	2004-05	Total for 3 years	Notes
Bro Morgannwg	£35,000	£35,000	£35,000	£105,000	Breakaway and physical restraint on an external contract. In-house training costs not calculated. From mid 2005, the Trust has appointed a violence and aggression co-ordinator plus administrative support at a cost of £53,000 per annum. They spent a further £128,000 capital on building new training facilities.
Cardiff and Vale	£162,125	£399,272	£707,079	£1,268,476	
Carmarthenshire	£10,000	£10,000	£61,411	£81,411	Situation, defusion, breakaway and physical restraint.
Ceredigion & Mid Wales		£3,525	£5,854	£9,379	External contract.
Conwy & Denbighshire	£200,000	£200,000	£200,000	£600,000	Defusion, breakaway and physical restraint.
Gwent Healthcare	£78,837	£70,921	£33,370	£183,128	This relates only to the trainer's salary employed within the Health and Safety team. The Trust also funds external trainers used in specialist areas through divisional budgets.
North East Wales	£35,000	£35,000	£35,000	£105,000	Salaries for physical restraint.
North Glamorgan	£48,000	£48,000	£48,000	£144,000	Defusion, breakaway and restraint.
North West Wales			£250,000	£250,000	The Trust has invested in additional in-house trainers for 2004 onwards (£78,000). Added to the existing staffing costs and consultancy services, the Trust will be spending in excess of £250,000 on training a year.
Pembrokeshire and Derwen		£2,400	£4,999	£7,399	Situation, defusion and breakaway. Internal trainers' time not quantified for customer care or restraint.
Pontypridd & Rhondda	£30,000	£30,000	£50,000	£110,000	Defusion and breakaway. Capital spending of £240,000 has been allocated for a new training centre for manual handling and violence for 2004-05.
Powys LHB	£1,000	£24,000	£18,000	£43,000	
Swansea	£36,500	£44,350	£48,150	£129,000	External contract
Velindre	£8,450	£6,343	£3,450	£18,243	External contract
Welsh Ambulance	£15,000	£20,000	£40,000	£75,000	External contract
Total	£659,912	£928,811	£1,540,313	£3,129,036	

Note: The £3.1 million total for three years represents only the direct costs of providing key elements of violence and aggression training and does not include the cost of participants' time or the cost of replacement staff, both of which can be considerable. All Trusts said that they have problems releasing staff for courses and providing additional staff to cover their duties on the ward to ensure continuity of care.

Source: Wales Audit Office survey of NHS Trusts in Wales and Powys Local Health Board



Appendix 4

Comparative data on violence and aggression in Wales, England and Scotland

1. Existing research shows that the problem of violence and aggression at work is not limited to the United Kingdom or to the health service. An international programme on workplace violence in the health sector shows that violence against health sector staff is a problem in many countries around the world. It reported that almost a quarter of all violent incidents at work are in the health sector and that just over half of health care workers have experienced violent incidents at work.
2. Paragraphs 1.30 to 1.35 discuss the problems with the existing data that is held on violent incidents as reported by NHS Trust staff. This makes comparisons of the levels of violent incidents with other countries in the United Kingdom difficult. However, we are able to produce data similar to those calculated for England based on our findings. **Figure 24** shows that reported average rates of violence and aggression across all Trusts in England for 2002-03 were a third higher (33 per cent) than the Welsh figures, with 11 incidents per 1,000 staff per month compared to 8.3 for staff in Wales. The rate falls to 7.6 for Wales in 2003-04 although there are no comparable figures available for England for the same period.
3. Comparisons with Scotland are not straightforward as there is no directly comparable data on violence and aggression. NHS Scotland reported that, of all occupational injuries in 2003-04, 54 per cent arose from violence and aggression in the acute health sector, with nursing staff and midwives accounting for 75 per cent of these reported incidents. A recent Audit Scotland report found high levels of violence and aggression on acute medical admissions wards and psychiatry of old age wards at some hospitals. An Audit Scotland survey of violence towards nurses found that a majority of hospital wards reported few incidents of violence and aggression. However, some acute medical receiving wards and psychiatry of old age wards had relatively high levels of reported incidents.

Figure 24 Reported incidents per 1,000 staff per month at all NHS Trusts in England and Wales

	Wales	England
2003-04	7.6 ^a	N/A
2002-03	8.3 ^a	11 ^b
2001-02	6.1 ^a	14 ^c

Sources: a. Wales Audit Office survey of all NHS Trusts and Powys Local Health Board;

b. Department of Health's 2002/2003 survey of violence, accidents and harassment in the NHS; and

c. National Audit Office, *A Safer Place to Work: Protecting NHS Hospital and Ambulance Staff from Violence and Aggression*, HC 527, Parliamentary Session 2002-2003.

Appendix 5

Violence and aggression policy in Scotland

1. The Scottish Executive has stated that “every NHS employee has a right to be protected from the risk of violence or infection in the workplace”. Policy direction on violence is included in the Partnership Information Network (PIN) Guidelines on people management which were launched in January 2003. The Scottish Executive has provided pump priming funding of £372,000 for ten different projects to combat violence and aggression across Scotland since March 2001. These projects were evaluated and discussed at a national conference in April 2004 which also took forward work to develop a violence and aggression strategy. A further £430,000 was allocated as matched funding.
2. Guidelines were issued to the courts in February 2003 asking them to treat more seriously attacks against public sector workers. This was followed up by legislation to protect workers attending emergencies, the Emergency Workers (Scotland) Act 2005, which received Royal Assent on 1st February 2005. Emergency workers covered include police, fire and ambulance staff and medical practitioners, nurses and midwives in hospitals, as well as social workers enforcing child protection orders and mental health officers. A person found guilty of an offence under this Act is liable to imprisonment for a period not exceeding nine months, a fine of £5,000, or both.



Appendix 6

Definitions of violence and aggression in use in Wales

These are the definitions in use by the NHS Trusts and Powys Local Health Board as well as the definition used for the All Wales violence and aggression training passport and information scheme. There are a number of minor variations in the exact wording of the definitions when applied to the NHS Trust's violence and aggression policy and the seven NHS Trusts listed that are marked with an asterisk (*) have specifically added verbal abuse to their definitions.

1. All Wales violence and aggression training passport and information scheme

Any incident where staff are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, wellbeing or health. This can incorporate some behaviours identified in harassment and bullying, for example verbal violence.

2. NHS Zero Tolerance zone

Any incident where staff are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, wellbeing or health.

Cardiff and Vale, Carmarthenshire, Pembrokeshire and Derwen, Pontypridd and Rhondda*, Swansea* and Velindre NHS Trusts.*

3. Health and Safety Executive

Any incident in which a person is abused, threatened or assaulted in circumstances relating to their work. (This can include verbal abuse or threats as well as physical attacks.)

Bro Morgannwg, Carmarthenshire, Ceredigion*, Gwent, North Glamorgan* NHS Trusts and Powys Local Health Board*.*

4. The Department of Health

The application of force, severe threats of serious abuse by members of the public towards people arising out of the course of their work whether or not they are on duty.

Cardiff and Vale and North East Wales NHS Trusts.*

5. Training course at the Centre for the Management of Violence & Aggression held at Ashworth Hospital, Liverpool

The application of force, severe threats or serious abuse by members of the public towards people arising out of the course of their work whether or not they are on duty. This includes serious or persistent harassment, including racial or sexual harassment, threats with a weapon, major or minor injuries and fatalities.

Conwy & Denbighshire NHS Trust

6. Risk Management 26

Violence is not only those occasions when physical harm is done, it can also include verbal abuse, threatening behaviour and bullying. (See also the Trust's policy on bullying and harassment). It can be perpetrated by patients, the public or other members of staff. Violence can occur as a result of the interaction between the public and the Trust personified by its staff. It is not necessarily personal, but can be the manifestation of some perceived grievance against the Trust or even the NHS generally. Some patients, their friends or relatives may be predisposed to violence, others may merely be confused, in pain or under particularly acute stress. Other identified causes of violence can be: the use or misuse of alcohol or drugs; long waits in Accident and Emergency or Out-patient Department; people suffering from some types of mental illness may commit acts of violence for no apparent reason.

North West Wales NHS Trust

7. Partially NHS zero tolerance zone campaign

For the purpose of the Trust violence and aggression policy, violence is defined as an action directed against a member of staff, arising out of work for the Trust. Such action may include a physical assault, harassment, or a threat by word, weapon or action which suggests a possible future act of assault.

The above action may be carried out by a patient, client, member of the public, other staff member or other third party.

Cases of verbal abuse would be included if they could reasonably be interpreted by the affected individual at the time as threatening in nature or likely to result in further acts of violence or aggression.

*Welsh Ambulance Service NHS Trust**



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