Ministerial Taskforce on Violence and Aggression in NHS (Wales)

Report and Recommendations

March 2008
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CHAPTER 1: INTRODUCTION

Since the World Health Organisation declared violence to be a “leading worldwide health problem” in 1996, successive reports have failed to halt the growth of this global phenomenon.

Healthcare workers who have face-to-face contact with the general public are considered to be at particularly high risk, with nurses being some 4 times the national average at risk of physical assault.

Whilst the numbers of serious physical assaults appears to be stabilising across the NHS sector, the trend has continued to increase in reported incidents which must be a cause for concern.

Health and Safety Regulations and other laws offer some protection to workers from perpetrators of violence and aggressive acts however, the reality of under-reporting and non-enforcement result in perpetrators receiving no punishment.
SUMMARY OF ALL RECOMMENDATIONS

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1. The All Wales Violence and Aggression Passport scheme should be accepted as the national minimum standard for NHS –Wales and should be incorporated into all training programmes for NHS-Wales staff.

2. Module A of the Passport scheme should without exception become mandatory for ALL staff working in NHS-Wales.

3. Module B of the Passport scheme should be mandatory for all staff who have direct patient and public contact.

4. Modules C & D of the Passport scheme should become mandatory for staff working in specific areas (eg Mental Health) subject to risk assessment.

5. Violence and Aggression Passport training should be incorporated as a component of Induction Training for ALL NHS-Wales staff and this should be updated every 2 years in compliance with the scheme.

6. NHS-Wales Employers should ensure that all 3rd party employees (eg; locum and agency staff, subcontracted staff) are all appropriately trained in compliance with NHS-Wales Passport scheme as part of contractual agreement with external contractors.

7. WAG should negotiate on behalf of NHS-Wales Employers with Education providers as part of Workforce Planning arrangements to ensure ALL students on placements in NHS premises receive Passport training prior to placement. No placements of students should be accepted without prior mandatory training. Negotiation must be on all-Wales basis to ensure consistency.

8. WAG should agree an all-Wales licence on behalf of NHS-Wales Employers to use one common electronic web-based system of data collection to expedite and facilitate easier direct staff reporting.

9. Statistical data collected via the system should be readily accessible to key stakeholders (including local staff-side safety representatives) to enable more transparent monitoring and benchmarking.

10. The common violence and aggression classification codes developed by the all-Wales Violence and Aggression Group must be implemented from 1st April 2008 to ensure consistency of prospective data collection.

11. All-Wales NHS Trust Boards should appoint an appropriate Executive level person to become a ‘V&A champion’ who will be responsible for monitoring performance and reviewing incidents of violence and aggression as well as the dissemination of organisational learning from reported incidents. This individual should also update the Board at least quarterly.
12. All NHS-Wales establishments ensure that local procedures are in place which will encourage employees to report ALL Violence and aggression incidents (physical and verbal) without exception.

13. Managers should actively promote the reporting of all violence and aggression incidents within their sphere of responsibility and be seen to take appropriate action(s).

14. Managers must investigate ALL reported incidents of violence and aggression within their sphere of responsibility. Such investigations should be undertaken promptly and be proportionate to the incident.

15. Managers must provide feedback promptly to victims and reportees, the progress and outcomes of all reported incidents. This will demonstrate action is being taken and encourage reporting.

16. All violence and aggression incidents must be reported using the agreed NHS-Wales reporting system promptly and no later than 2 working days post-incident.

17. There should only be one common reporting system across NHS-Wales which will hold ALL details of reported incidents of violence and aggression. No secondary systems (confidential, ‘special’ or otherwise) should be operated.

Prosecution

1. The MoU with the CPS was previously signed in March 2007 (Appx C). NHS-Wales trusts are required to implement the agreements and practices within this MoU.

2. The MoU with ACPO (Wales) should be signed by the Health and Social Services Minister to launch the agreement upon completion.

3. The domestic violence model be followed and applied to cases of violence and aggression against NHS-Wales staff.

4. It is recommended that a local Police presence on NHS premises be introduced in specific areas following success of other similar initiatives.

5. Implementing and funding the stationing of Police Officers in key NHS-Wales areas be funded and nationally agreed/negotiated.

6. A National pilot to improve and extend CCTV usage within A/E departments in all large hospitals across Wales.

7. The results of the pilot should be considered and then extend the CCTV to all-Wales NHS facilities.

8. All-Wales NHS Employers should ensure guidance is in place in all areas to support the management of violent and aggressive situations involving perpetrators with a mental health or challenging behaviour disorder.

Support

1. All victims of violent/aggressive acts in NHS-Wales should be ‘fast-tracked’ via NHS waiting lists to ensure speedy and appropriate therapeutic interventions.
2. Occupational Health Departments should be the ‘gatekeepers’ of services for victims and ALL staff should be able to access an OH Physician at the earliest opportunity and no later than 3 working days post incident.

3. All-Wales NHS Employers shall have in place systems to enable such prompt referrals (including self-referrals) – and where required, access to Counselling services within 3 working days post-incident.

4. The use of Neurolinguistic Programming (NLP) as an additional tool for staff victims should be further investigated to determine effectiveness and appropriateness of usage across NHS-Wales.

5. The ‘Staff Wellbeing Service’ within Cardiff and Vale NHS Trust is an exemplar model of staff support for psychological injury. This model should be adopted in centres across NHS-Wales to enable all staff to benefit. Alternatively funding should be provided to enable the Cardiff centre to accept referrals on an all- Wales NHS basis.

6. WAG should consider what actions they can take to influence a change in national terms and Conditions via the NHS Partnership Forum. This change should remove the discretionary element of Sect 14:9 to require managers to extend sick pay at full rate. Until this can be agreed, the HSS Minister should issue guidance to NHS-Wales Employers encouraging the exercise of positive managerial discretion in such circumstances.

7. NHS-Wales Employers should provide any necessary additional therapeutic support to encourage and enable staff victims to participate as witnesses to prosecute perpetrators.

8. WAG should commission additional independent research to identify why there is an apparent reluctance amongst NHS-Wales staff to support prosecutions as witnesses and identify solutions to encourage staff to engage.

9. NHS-Wales Employers to provide staff with free access to and support from their Agent Solicitors to pursue prosecutions and recovery of additional costs incurred as a consequence of violent and aggressive acts at work.

10. WAG should ensure that revised guidance includes recommendations to all-Wales NHS employers on; care and restraint techniques, recording of data and the provision of training for staff.

**Lone Working**

1. It is recommended that this business case for automated alert system for NHS-Wales be accepted and that funding is provided from WAG for one of the suggested options.

**Management of Groups under influence of alcohol in A/E departments**

1. This subject should be considered in greater detail by an appropriate and established group.

2. WAG should, following such consideration develop all-Wales facilities, training systems and staff guidance for staff in the management of
patients/clients and groups presenting in A/E Departments – particularly where violence and aggression are present.

General

1. It is recommended that violence and aggression be kept under review during the implementation of recommendations and in any case should be reviewed on an all-Wales basis within 3 years.

2. WAG should launch a high profile public awareness campaign to support the recommendations of the Taskforce and remind the public how violent and aggressive behaviour towards NHS-Wales staff will not be tolerated. Such a campaign must be enduring beyond simply ‘a launch’ to support embedding of the recommendations.

3. NHS-Wales Employers should develop internal and external communication strategies to ensure maximum media exposure of actions against all perpetrators.

4. WAG funding should be provided to launch and support an enduring media campaign showing the unacceptability of violence and aggression in NHS-Wales – revising the concept of zero tolerance.

5. WAG should update and reissue WHC (2002)09 – “stopping violence and aggression against staff working in the NHS” and WHC (2002)82 “tackling violence against those in primary care”.

6. All future ‘new builds’ and significant upgrades/renovations to existing NHS facilities should be compliant with ‘secure by design’ and ‘safer hospital concepts’ which requires plans are subject to approval by qualified WHE and Police architectural Officers.

7. All smaller schemes commissioned by all-Wales Employers should be subject to ‘secure by design’ suitability checks

8. All-Wales NHS Employers should be encouraged to work with local safety partnerships in tackling crime and anti-social behaviour in healthcare premises and other areas where healthcare may be provided.

9. Community, primary Care and LHB provisions should be considered equally with regard to reviewing arrangements and implementing the taskforce recommendations. Due to the nature of the environment, special timescale, funding and approaches may be required to support implementation in these areas.

10. WAG must ensure adequate funding (capital and revenue) is made available to ensure compliance with statutory guidance and regulations, development of best practice and implementation of taskforce recommendations in full.

11. WAG must ensure systems are developed to regularly review compliance of all-Wales NHS Employers regarding (10) above.

12. WAG should fully endorse an approach to increase the number of prosecutions of perpetrators of violent and aggressive acts against NHS-Wales staff.
CHAPTER 2: AGREED TERMS OF REFERENCE

Task Force to deal with Violence and Aggression in the NHS

Draft Terms of Reference

1. Purpose and Aim of the Taskforce

1.1 To look at a range of issues to improve the protection of staff working in the NHS in Wales from violence and aggression.
1.2 To set practical standards for achievement of this.
1.3 To set timescales for implementation of these standards, and
1.4 To monitor implementation of these standards

2. Role of the Taskforce

2.1 To provide advice, guidance and recommendations to the Minister for Health and Social Services on dealing with violence and aggression to NHS staff.

3. Functions and Objectives of the Taskforce

3.1 The main four objectives this taskforce will address are:

- **Incident Reporting** – The NHS must ensure that incidents are reported for all types of violence and aggression and that staff feel that their employer is taking all reasonable steps to investigate to prevent them from reoccurring. Consequently the taskforce will develop common incident reporting codes which will allow them to provide accurate information and benchmark across Wales.

- **Taking Action Against the Perpetrators of Violence** – The taskforce will ensure that there are mechanisms in place to take action against anyone who is willfully violent towards staff or fellow patients. Guidance will be developed to ensure the NHS has in place robust systems for working with the police and crown prosecution service to ensure that these perpetrators are dealt with sternly. The task force will also look at ways in which information on these perpetrators can be shared across the NHS in Wales.

- **Support for Staff after an Incident** – Further guidance will be issued on the measures the NHS must take to support their staff following a violent attack. This could range from the physical,
emotional or even legal support to ensure that staff feel valued by their employer.

- **Lone Workers** – The taskforce will provide recommendations on how to best manage the safety of lone workers and will provide options for the provision of an all Wales lone workers alert system.

4. Reporting Arrangements

4.1 The Violence and Aggression Taskforce will report directly to the Minister for Health and Social Services for endorsement. The Taskforce will provide an interim report to the Minister in March 2008 followed by the final report with recommendations in July 2008.

5. Membership

5.1 Current Membership

Trade Union Representatives – One Each from UNISON, AMICUS, Royal College of Nursing, British Medical Association, Chartered Society of Physiotherapy (or Society of Radiographers) and GMB
The Health and Safety Executive (Wales)
The Chair of the NHS Wales Health and Safety Advisers Forum
The Chair of the NHS Wales Violence and Aggression Steering Group
Nurses from:
- Mental Health
- Accident and Emergency, and
- Community Health
A NHS Security Manager
A NHS Chief Executive

5.2 With the agreement of the group others may be co-opted to join the Task and Finish group on an ad-hoc basis.

5.3 The term of office of the Chair will be for the period of the Taskforce.

5.4 If the Chair stands down before the completion of the project, a new nomination will be sought.

5.5 Administrative and technical support will be provided by the Executive Officer to the Occupational Health and Safety Policy Lead.
6. Quorum and Attendance at Meetings

6.1 The Violence and Aggression Taskforce will meet as necessary.
6.2 The meeting will be quorate when a minimum of half the representatives are present.
6.3 Members are expected to attend all meetings. Non attendance to two consecutive meetings is reason for the Chair to consider a request for replacement.
6.4 If members are unable to attend a meeting, a replacement representative should be designated with prior notification to the Executive Officer.

7. Agenda, Minutes and Record Keeping

7.1 All members of the Task and Finish group have the right to submit appropriate agenda items. Requests for agenda items should be made to the Executive Officer ten days before the date of the forthcoming meeting.
7.2 The agenda and any supporting papers will be circulated a minimum of seven days before the meeting.
7.3 Minutes will be circulated seven days after the day of the meeting. A formal record will be signed by the Chair and kept in a proper manner.

10 January 2008
CHAPTER 3: BACKGROUND

In Wales the upward trend of violence and aggression towards NHS staff very much reflects the NHS-UK picture. Data from the most recent Staff Survey and known reported incidents over the preceding 3 year period suggests urgent action is required at an all-Wales level.

The Minister for Health and Social Services announced in October 2007 the establishment of a Ministerial Task Force to recommend a range of issues to improve the protection of NHS-Wales staff. The Task Force would consider violence and aggression across all sectors of NHS-Wales and were specifically asked to address three key elements related to violence and aggression; incident reporting, prosecution of perpetrators and support for staff who are victims.

The Taskforce subsequently included Lone Working and were later requested to consider how accident and emergency staff should respond to groups presenting in the department under the influence of alcohol.

The identified themes all represent key areas for action if violence and aggression against NHS-Wales staff is really going to be tackled.

**Under-reporting**; is a recognised problem across the UK generally. If we do not accurate data of reported incidents with detailed classification codes to enable effective monitoring the situation will never improve. More concerning is the feedback from staff which suggests part of the rationale for not reporting is a disinterest by employers and a belief that things will never get better as employers don't care.

**Prosecution**; is a contentious area where little progress appears to be made in managing violence and aggression. Evidence suggests that very few cases in Wales are ever prosecuted and offenders believe they can ‘get away with it’ and repeatedly offend. The current system of dealing with such perpetrators by a fine which is rarely enforced remains inappropriate as a response to such actions. More robust systems should be developed to apprehend, prosecute and publicise cases to reinforce a zero tolerance approach across NHS-Wales.

**Support to victims**; remains an area where NHS-Wales have performed poorly. The greatest asset NHS-Wales has must be its’ staff, yet they receive inconsistent levels of support which are often based upon severity of injury, geography and the discretion of the employer. NHS-Wales staff who are victims of violent and aggressive acts lose out financially through loss of earnings which is often compounded by trying to access therapeutic services which have very lengthy waiting lists.

**Lone Workers**: have been identified as a particular high risk group where statistically in excess of 50% will be subject of verbal abuse and 10% will suffer some form of assault at work. NHS-Wales cannot ignore the potential for serious harm and must take immediate action to protect such staff.

Each of these key themes has been considered by the Taskforce in greater detail and a series of 54 recommendations have been offered to help address the overall problems of managing violence and aggression in NHS-Wales.
CHAPTER 4: DATA

Consideration of available data has informed the taskforce. The available data was a review of the reported incidents from all-Wales NHS employers in the period 2003-2006.

This three year period provides very limited information as there are inconsistent data collection methods and systems across the NHS. Initial review of the data shows that there is no real difference in reported incidents between areas such as accident and emergency, ambulance personnel and general surgical or medical areas.

Reported incidents of violence and aggression against staff by patients are much higher than incidents reported from visitors. Mental Health and Learning Disabilities do show high rates of reporting.

The overall trend does show an increase year on year. There is no universal means of identifying which of the reported incidents arise from unacceptable behaviour and which arise in patients as a consequence of some therapeutic or clinical reason (e.g., dementia, post anaesthesia).

This information was discussed with Health and Safety lead in some Trusts and LHB’s. The discussion reinforced a suspicion of under-reporting of incidents. Other key factors discussed ranged from benefits of CCTV and resident police officers to staff being burdened with documentation and competing clinical matters with staff shortages – all accounting rationale for why issues were not reported.

There appears to be a culture of acceptance in some areas that violence and aggression are ‘part of the job’ and “goes with the territory” attitude. Alongside this is a view amongst many staff that reporting is pointless as “nothing is ever done” and “nobody cares ...it’s just statistics”. There is additionally an apparent view that verbal aggression is more readily acceptable in front line areas such as ambulance personnel and Accident/Emergency departments, to the extent that verbal incidents are rarely reported from these areas.

Interviews were also undertaken with a number of ‘staff victims’ of violent acts at work who expressed mixed views about support from local managers whilst on sick leave – ranging from excellent and compassionate/supportive through to “couldn’t care”. Whilst some staff felt access to local heath services was good there was little evidence of ‘fast tracking’ for outpatient or clinical services other than counselling or medical reports for health reviews to agree retirement and termination.

There is clearly an inconsistent approach to support and services available across Wales for NHS staff victims.
All staff members interviewed who had been on sick leave for more than 6 months (2 staff members 4 months) had reduced salary. Not all were accessing NHS Injury Benefits and consequently had financial losses incurred well in excess of 15% of their salary. Two staff members claimed to have been well enough to work but not allowed to return because they were awaiting specialist medical opinions (in excess of 5 months).

The reported incidents data, Employers Safety Leads and Staff Victim information were triangulated against the most recent data to arise from the 2007 NHS-Wales Partnership Forum Staff Survey results. Although this survey response was low (31%), it did reflect reported feelings of staff and Leads that under-reporting was a significant factor due to lack of belief that anything would happen to change things(52%). As significant is the failure to report due to time (17%) which reflects views that work pressures and bureaucracy play a part in under-reporting.
CHAPTER 5: FINDINGS

Having reviewed the available data from NHS-Wales reported incidents between the period 2003 and 2006 (most recent) and discussing the data and conclusions from this with key stakeholders including managers, Trust Health and Safety Leads, NHS-Wales staff, NHS-Wales staff victims. It is clear the quality of data is both inconsistent and not fit for purpose at an all-Wales level and better systems of data collection and monitoring are desperately required.

The evidence strongly supports a view that significant under-reporting occurs across NHS-Wales and staff need to be strongly encouraged to report ALL incidents of violence and aggression whether verbal or physical without exception. Such encouragement can best be provided from communications to staff that action is taken and that reports are treated seriously. As importantly this needs strong actions and leadership at an All-Wales WAG level to demonstrate zero tolerance of violence and aggression to staff as well as a strong show of commitment and support from WAG and senior all-Wales NHS employers.

Much of the changes required to make a difference are cultural and will consequently take some time (several years) to really embed. Others are easier to implement and may have associated costs, but this will be helpful in demonstrating commitment to NHS-Wales greatest asset – its staff.

All available evidence shows violence and aggression to NHS-Wales staff exists, is continuing to grow, current systems are not effective and change is desperately needed.

Clearly measures such as safe and appropriate staffing levels and rich skill mix will be helpful in continuing the delivery of services more effectively and will enable policies, procedures and guidance to be more readily adhered to. However, these alone will not stop the increasing violence and aggression towards NHS-Staff. Specific measures are required which need resourcing and continued commitment at the highest levels across NHS-Wales, alongside training, development, change and valuing staff.

Robustly pursuing and prosecuting perpetrators is essential to effectively supporting NHS-Wales staff and promoting a true zero tolerance model within NHS-Wales.

The themes of reporting, prosecution, staff support and lone working have each been fully explored and the 54 recommendations are each entirely justified from the available evidence, data and experience.
CHAPTER 6: IDENTIFIED THEMES;

REPORTING

One of the key themes identified by the Minister for consideration was the reporting of incidents. Review of available data suggests significant under-reporting of incidents and the group have considered; how staff can be encouraged to report, how it can be made easier to report and develop better reporting systems and data.

Key issues also explored were consideration of Organisational and local geographical cultures, consistency of systems across Wales, corporate ‘buy-in’ and Leadership and Management which all impact upon reporting.

Key recommendations:

NHS-Wales have developed a ‘passport scheme’ to support violence and aggression in NHS employment. The scheme provides appropriate modularised training to meet basic needs for all staff to more advanced levels of training based upon localised risk assessment. The passport is not consistent across NHS-Wales as many employers are not yet compliant with passport scheme. To agree the all-Wales passport scheme for NHS-Wales sends a clear message of minimum standards required across Wales and provides consistency of approach for all staff making it easier to update skills upon transfer between employers.

- The All-Wales Violence and Aggression Passport scheme should be accepted as the national minimum standard for All-Wales NHS Employers and should be incorporated into all training programmes for NHS staff. Such training may be provided to staff via induction programmes or where applicable via Colleges and University programmes of preparation.
- Module A of the Passport scheme should be mandatory for ALL staff without exception.
- Module B should be mandatory for ALL staff who have direct patient and public contact
- Modules C&D of the scheme should be mandatory for staff in specific working areas (eg Mental Health) and subject to specific risk assessment.
- Violence and aggression passport training should be incorporated as a key component of all induction training.
- Mandatory updates are required for all staff every 2 years in compliance with passport scheme
- NHS-Wales Employers should ensure that 3rd party employers such as Agency and Locum Staff, temporary staff and subcontracting workers are all appropriately trained to NHS-Wales standard at point of contractual agreement with external contractors.
Welsh Assembly Government should negotiate on behalf of NHS Wales Employers with Educational Providers as part of workforce planning to ensure ALL students on placement in NHS premises have received V & A passport training prior to any placements. No placements of any Students are acceptable without prior mandatory training. The training should be negotiated at an all-Wales level to ensure consistency of approach.

Under-reporting of incidents is believed to be a significant matter in NHS-Wales. Reasons often given to account for this are often associated bureaucracy and available time to complete lengthy forms. The data collated via current reporting systems is inconsistent and insufficiently specific for need in a changing situation. Web-based reporting systems with more specific data codes for future research can be more readily and effectively collected via web-based technology. This also reduces bureaucracy and time in form completion as well as accuracy of data.

- Welsh Assembly Government should agree an All-Wales licence for NHS Employers to use one common electronic, web-based system of data collection to expedite and facilitate easier direct staff reporting
- Statistical data collected via the system should be readily accessible to key stakeholders (including local staff side safety representatives) to enable more transparent monitoring/benchmarking
- The common V&A classification codes developed by the All-Wales Violence and Aggression Group must be implemented across All NHS-Wales facilities from 1st April 2008 to ensure consistency of prospective data collection

Responses received from NHS-Wales staff strongly support a view that people fail to report incidents because of a belief that nothing will change and management are not interested or committed to addressing problems. It is important to demonstrate to staff that responsible employers are not only required to take violence and aggression seriously, but they want to. Consequently a commitment from the highest level in each NHS-Wales employer will be a strong indicator of change for staff, which will in turn encourage reporting and positive actions.

- All-Wales NHS Boards should appoint an appropriate Executive level person to become a ‘Violence and Aggression Champion’ who will be responsible for monitoring performance and reviewing incidents of violence and aggression across their Board. Promoting a positive culture with regard to violence and aggression and the dissemination of organisational learning from reported incidents, this individual should also update the Board at least quarterly.
- All NHS-Wales establishments ensure that local procedures are in place which encourages employees to report ALL V&A incidents (physical and verbal) without exception.
- Managers should actively promote the reporting of all V&A incidents within their sphere of responsibility and be seen to take appropriate action(s).
Good communication between employers, managers and employees involved in violent and aggressive incidents is vitally important. Victims and witnesses report that lack of feedback post incident generates negative perceptions about employer commitment and support. Investigations may be undertaken and staff receive no updates on progress or outcomes which leaves them feeling undervalued and uncertain of action(s) taken.

Similarly investigations may be undertaken into situations which are disproportionate to the level of incident. Local procedures may set out stages of procedure to be adhered to which can be inappropriate and resource intensive for the circumstances.

- Managers must investigate ALL reported incidents of V&A within their sphere of responsibility. Such investigations should undertaken promptly following notification and be proportionate to the incident.
- Managers must provide feedback promptly to victims and reportees, the progress and outcomes of all reported incidents. This will demonstrate action is being taken and encourage reporting.

Prompt reporting ensures accurate and up to date data is available for analysis and actions are taken in a timelier manner. Reporting is not a single act, but an action which may set in motion a chain of responses which will be critical to prevention and follow-up. Using one standard system of data collection for monitoring all-Wales NHS is essential for consistency monitoring and it is not appropriate for Employers to maintain separate reporting systems which can be produced, causing inaccurate statistics and understandings of local situations.

- All V&A incidents must be reported using the agreed NHS-Wales reporting system promptly and no later than 2 working days post incident.
- There will be only one common reporting system across NHS-Wales which will hold all categories of reported V&A incidents. No secondary reporting systems (confidential, 'special' or otherwise) should be used.
PROSECUTION

This section details the measures to be considered when addressing how to punish the perpetrators of violence and aggression against NHS Trust staff.

It was actually suggested that the Health Minister might wish to consider announcing that all perpetrators of violence against NHS staff would be charged for their healthcare.

Detailed below are the measures, which also include considerations on risks and resources:

Working with the Police and Crown Prosecution Service

A small working group, lead by NHS HR Division of the Welsh Assembly Government and Welsh Health Legal Services has in partnership developed a series of Memorandum of Understandings (MoU). These MoUs are between the following stakeholders: the Department of Health and Social Services in the Welsh Assembly Government, NHS Trusts and Local Health Boards, the Crown Prosecution Service (Wales) and the National Association of Chief Police Officers (Wales).

- The MoU with the CPS was signed by the Director of Public Prosecutions, Sir Ken MacDonald and Dr Brian Gibbons, the then Health Minister for Wales in March 2007 (see Appendix C). There are targets in this year’s National Operating Framework which require NHS Trusts to implement some of the agreements and working practices in the MoU.

- The MoU with ACPO is nearing finalisation and it is recommended that Mrs Hart, the Minister for Health and Social Services formally signs and launches this important agreement as part of a Violence and Aggression against NHS staff campaign.

- The MoU launch can link with the other measures detailed in this report and form part of a media campaign for both NHS workers and the general public. A copy of the latest draft of this MoU is attached as Appendix B.

The key issues both MoU’s will address are Communication and Partnership at a local level. Trusts and LHBs are to work locally with police forces and the CPS to help with the prevention, detection and disposal of those perpetrators of violent or aggressive crimes against NHS staff. Meeting structures and other communication channels are to be agreed between all parties both nationally and locally over the coming months.
Using the Domestic Violence Model

There is currently an initiative running between the CPS and ACPO that gives priority to all reported incidents of Domestic Violence.

- It is recommended that the same model is followed and applied to cases of violence and aggression against NHS staff in Wales.

This would see the introduction of measures to prioritise and respond to emergency calls, how they are detected and recorded and the establishment of special courts to deal with punishing perpetrators.

Local police and Trusts are to work closely to ensure there is an increase in reported incidents of violence against NHS staff and how these cases are investigated and recorded. There is a suggestion that the Crime Databases for all four Welsh forces are amended to include ‘NHS’ as a category. This will ensure prioritisation of these incidents by the police and also provide more up to date data to the NHS.

- It is recommended that a local Police presence on NHS premises be extended following success in some NHS Units where Police are currently ‘stationed’. This issue should be nationally agreed and funded thereafter, subject to local risk assessments between Police and NHS-Wales employers to determine most appropriate local arrangements.

Alongside this, it has been suggested by both the police and CPS that improvements to Closed Circuit Television (CCTV) Systems in Hospital premises will allow for better detection and prosecution of perpetrators. It was stated by both parties that CCTV can allow a Trust to lead on a prosecution reducing the stress on the individual and also giving a clear message to the general public that NHS Trusts will not tolerate assaults on their staff.

- It is recommended that a National initiative is undertaken to improve CCTV within A&E departments in all large hospitals. Data will be captured before their introduction to allow measurements to be made to see if their introduction directly affects the level of incidents of violence and aggression. Other monitoring would also be put in place to determine the levels of prosecutions of perpetrators using CCTV footage.

One major issue that requires further work with all stakeholders is dealing with perpetrators of violence against NHS staff where the perpetrator suffers with a
recognised health condition which may precipitate the violent or aggressive act (e.g.; dementia, psychoses, challenging behaviour disorder).

- It is recommended that all stakeholders develop specific guidance on this particular issue.

Prosecution of perpetrators is an important theme which this Taskforce has considered and work continues in this regard. It is anticipated that following further discussions with Counter Fraud and Security Management Services (CFSMS) which will not be concluded until shortly after the submission of the Interim Report, further recommendations will follow from the Taskforce.
SUPPORT FOR VICTIMS

Staff, who are victims of violent and aggressive acts at work, should not suffer detriment as a consequence. Interviews with staff victims, managers and Trade Union Representatives have helped the taskforce in considering this theme.

Staff, are NHS-Wales greatest asset and are often disadvantaged following incidents in at least two key areas; therapeutic and financial. Recognising this unacceptable situation which has a negative impact upon NHS-Wales sickness/absence figures and resources action is required to help redress the imbalance.

Staff victims are generally able to continue working after incidents but in some cases there may be a brief period of sickness/absence. More serious cases result in staff remaining on sick leave for lengthy periods of time. In some cases the absence may be for a direct clinical reason where the individual may simply be unfit to return. In some cases however, the absence is prolonged as a consequence of being unable to access clinical services/support due to NHS Waiting lists. This places an avoidable cost and pressure upon the service.

Many staff may have a resultant psychological injury which evidence supports is best resolved by early intervention. Cognitive Behavioural Therapy (CBT) is a common response to such situations and should be provided at earliest possible opportunity for maximum efficacy. Current waiting lists to access CBT in NHS-Wales can be in excess of 9 months.

Greater access to and provision of services is essential in supporting staff who are victims of violent and aggressive acts whilst on duty. Some NHS Trusts can be viewed as exemplars in services provided for staff, but the access to and provision of such services is inconsistent across Wales.

Staff who can access speedier NHS support following incidents (physical and psychological) will be likely to have much better recovery rates and will cost NHS-Wales less by reducing sickness/absence costs.

There is some suggestion that alternative forms of support such as Neurolinguistic Programming (NLP) may have a place in supporting staff psychologically. It is asserted that such treatments can be quicker and allow staff to return to work and cope much faster than conventional models of treatment such as CBT. The group have not been presented with empirical evidence one way or the other but consider further exploration of alternative tools may be worthy of further investigation.
The Taskforce considered the ‘support’ theme and make the following therapeutic, financial and general recommendations.

**Therapeutic:**
- All victims of violent/aggressive acts in NHS-Wales should be ‘fast-tracked’ via NHS systems and waiting lists to ensure they receive more appropriate and timely therapeutic interventions for all/any physical, psychological/emotional condition resultant from the original act.
- Occupational Health Departments should be the gatekeepers of services for victims and ALL staff should be able to access an Occupational Health Physician at the earliest opportunity but no later than 3 working days post incident.
- All NHS Trusts should have in place systems to enable such prompt referrals (including self-referrals) and where required access to Counselling Services for staff victims within 3 working days post incident.
- The use of NLP as a tool for staff victims across NHS-Wales should be considered in some greater detail to determine its appropriateness for wider usage. A group of appropriate Specialists in the field should review and research this topic and report findings for consideration at an early opportunity.
- The Staff Wellbeing Service/PTSD clinic, Cardiff and Vale NHS Trust is an exemplar model of service provision for staff. Consideration should be given to funding additional similar Units across Wales or enabling all-Wales staff referrals to the Cardiff Unit to ensure consistency for all NHS-Wales staff victims.

**Financial:**
In addition to the ‘injury’ received, staff, are again disadvantaged financially. Generally staff salary whilst on sick leave will reduce to half pay following a maximum period of 6 months. NHS Injury Benefits can be applied which will *(if approved)* up rate the sick pay to 85% of normal earnings. This still represents a loss of 15% salary for many staff which is only recoverable via legal proceedings.

In addition to these losses, many staff frustrated by lengthy waiting lists resort to paying privately to access services such as MRI scans, physiotherapy and psychological support *(and in some cases private medical consultations).*

- WAG should consider what actions they can take to influence a change in NHS-Wales Agenda for Change terms and conditions via National (UK) Partnership Forum to **require** employers to exercise the discretionary element and ensure staff who are victims of any violent/aggressive act whilst at work continue to receive full pay for the duration of their related sickness/absence period.
- Until such times as agreement to amend the terms and conditions of NHS-Wales staff can be reached. The Minister for Health and Social Services should issue guidance to NHS-Wales employers encouraging the exercise of positive managerial discretion in such circumstances.
Staff who are injured as a consequence of a violent/aggressive act at work should receive no detriment financially or in respect of terms and conditions. NHS-Wales employers should provide every reasonable assistance to staff victims to support prosecutions and enable recovery of personal cost including where requested and appropriate Legal advice, support and representation. Often victims may feel pressurised not to support prosecutions as this can follow a traumatic experience and might appear to extend the symptoms and distress caused by the original act. Pursuing litigation can be a daunting prospect and having the support of Employers to consider the merits of prosecution and recovery of personal costs without financial risk to the victim would be a great advantage. This would additionally assist the Employer who will be keen to influence as many prosecutions as possible.

Guidance and support are helpful to employers and employees when considering responses to constantly changing situations including management of violence and aggression in the workplace. To ensure consistency of approach it is best that as much of the guidance is developed and disseminated centrally as local protocols will inevitable vary.

General support:
- NHS –Wales Employers should provide any necessary additional therapeutic support to encourage and enable staff to actively participate as witnesses to violent and aggressive acts.
- WAG should commission some additional independent research to identify why there is an apparent reluctance amongst NHS staff to support prosecutions as witnesses.
- NHS-Wales Employers should provide staff victims with free access to and support from their agent solicitors to pursue prosecutions and recovery of additional costs incurred as a consequence of violent and aggressive acts at work.
- WAG should ensure revised guidance includes recommendations to employers on; care and restraint techniques, recording of data and the provision of training for staff.
LONE WORKING

Lone workers are an extremely vulnerable group of employees in NHS-Wales who are statistically at greater risk than almost any other category of worker. There are very many Lone Workers across NHS-Wales who on a daily basis continue to deliver care to patients in a diverse range of settings across Wales, often in very remote areas.

Face to face contact with patients and visitors is essential to delivering high quality services yet it is this very aspect of care delivery which places NHS-Staff at greatest risk. For lone workers, this presents a much greater challenge as they will be away from the relative safety and security of colleagues and familiar environs. Community staff in particular meet the patients and their family in unfamiliar surroundings, not knowing what lies behind the door. Risk assessment is the only tool available to measure the risk and consider response.

The Suzy Lamplugh Trust in a 2005 survey identified that in excess of 50% of lone workers were regularly subjected to verbal abuse and that around 10% of lone workers had experienced some direct physical assault whilst at work. The concern for NHS-Wales must be the very limited data which is available. It is not clear how well NHS-Wales performs against the wider Lamplugh data as it until now has not been routinely collected and the extent of under-reporting is not really known.

The Health and Safety Executive laboratory also reported in 2005 the most common risks associated with lone workers included; alcohol and drug use by contacts, the location, hours of lone working, nature of the job, client behaviour, external factors, travel, visiting homes, carrying money, drugs, equipment.

In identifying these common risks, the HSE helpfully outline 4 key themes to manage the risk which are; Training and information, Communications, Equipment and environment, Job design. Each of these themes are essentially considered as part of risk assessment which is critical. However, this still remains the only real tool available to lone workers and an automated alert system would benefit and reassure lone working NHS-Wales staff.

Attached as Appendix F is a business case and technical specification for the provision of an automated alert system for all staff who work alone in NHS Wales.

- It is recommended that this business case is accepted and that funding is provided from WAG for one of the suggested options.
Dealing with drunk/intoxicated attendees to accident and emergency departments is a very significant problem for NHS-Wales. The taskforce were asked at a late stage to consider recommendations to assist in management of this category of threat.

Timescales did not support the taskforce undertaking any extensive research or detailed consideration of this matter other than to identify that alcohol may not be the only/main form of substance to be considered. The remit should be extended to incorporate all forms of substance misuse.

All NHS-Wales Trust Chief Executives were asked to provide copies of the current guidance and information issued to Accident and Emergency Unit staff in such circumstances. Ten NHS Trusts responded (83% response) and no documentation addressing how staff dealt with ‘drunks’ in A&E specifically appears to exist.

All Trusts had a Health &Safety policy that included zero tolerance to violence and aggression and reported that staff attended training conforming to the All Wales Violence and Aggression Passport. The majority of Trusts undertook risk assessment within A&E Departments that covered V&A. Most Trusts included copies of their ‘patient undertaking’ system in place for persistent violent/abusive patients/visitors.

Several Trusts reported that V&A incidents had decreased significantly when the police were sited in A&E.

Examples of existing good practice:

A ‘2 minute V&A risk assessment’, was being used by 2 Trusts, a simple and quick approach that would not add to the staff burden, whilst covering the topic.

Several trusts included checklists of behaviours to watch out for/indicative signs from patients who may be violent.

Several trusts included checklist highlighting of staff behaviours that may exacerbate violence/aggression and calming/neutral behaviours that were encouraged.

Most trusts encouraged staff to report incidents but only one instructed staff specifically to document a violent occurrence in the patient care plan.

One trust reported that they had developed a good dialogue with the Ambulance Trust so that they are aware of patient condition prior to arrival. Allowing the trust to have suitable staff to receive the patient, including the presence of a police officer where necessary.
Several Trusts have developed information pamphlets for staff relating to violence and aggression, common elements include, a trust statement, how to obtain emergency support, what to do post incident, and where to get post incident support. The evidence is compelling that where guidance exists and "best practice is adopted, outcomes are better, however there is inconsistency across NHS-Wales in developing local guidance and sharing best practices.

Considering the limited time and data available the Taskforce recommend;

- This specific piece of work be referred for more detailed consideration to an appropriate and established group (eg: Drug and alcohol triage programme)
- WAG should following such consideration develop all-Wales facilities, training systems and guidance for staff in managing the receipt of patients/clients and groups in A/E departments – particularly where aggression and violence are present.
- WAG should issue guidance on the management of groups who present under the influence of alcohol/substance abuse in addition to any further recommendations.
GENERAL RECOMMENDATIONS

All stakeholders across NHS-Wales share the responsibility to reduce violence and aggression in the workplace. Partnership Working with Trades Unions is integral to success of all Taskforce recommendations.

Much of the success of the recommendations will be dependant upon management of change and culture within and across NHS Wales and specific time and resource will be required to ensure this happens. The recommendations within this document are not going to produce immediate resolution to such a major problem but will require a significant period of some 3-5 years for recommendation embedding.

- It is recommended that violence and aggression be kept under review during implementation phase but this should be reviewed on an all-Wales basis within 3 years.

Cultural changes within organisations and across society are key features of eradication of violence and aggression in NHS-Wales. It appears that some forms of unacceptable behaviours are now almost accepted as norms – this view needs to be changed and engagement and education of the general public and staff are paramount.

Unacceptable behaviours have now been tolerated in NHS-Wales for far too long despite the message that it will not. Encouraging prosecutions and as importantly, ensuring they are widely covered in all local and national media will signal a step change which the public must be made aware of. It is anticipated that such a public approach also discourage potential perpetrators. The use of all forms of media to profile violence and aggression must be considered locally and nationally as a positive and helpful tool in the fight back against NHS-Wales staff abuse.

- WAG are urged to launch a high profile public awareness campaign across Wales which will launch a new approach to violence and aggression in NHS-Wales, highlighting how unacceptable behaviours against NHS-Wales staff will not be tolerated. Such a campaign must be enduring to ensure that this important issue is maintained in the public domain whilst strategic change is embedded.
- NHS-Wales Employers should develop internal and external communication strategies to ensure maximum media exposure is achieved locally to highlight actions taken against perpetrators following prosecution.
- WAG funding should be identified to launch an all-Wales media campaign in press and TV, showing the unacceptability of violence and aggression and launching a public awareness campaign marking a new approach of zero tolerance.
• WAG should commission a national awareness campaign to promote the message that violence and aggression in any form, will not be tolerated against NHS staff in Wales
• WAG should update and reissue WHC (2002)09 – “stopping violence against staff working in the NHS” and WHC (2002)82 “tackling violence against those in primary care”.

NHS premises should be a place where patients can be cared for and staff can provide high quality care and services free from threat or abuse. The physical environment/buildings in which NHS staff work vary in size, location and fitness for purpose. There are examples of many new builds and upgrades to old establishments across Wales over many years which have not fully considered appropriateness of facilities for changing need and purpose or indeed with staff safety and needs in respect of violence and aggression.

• It is recommended that all future new builds and significant renovations to existing facilities should be compliant with ‘secure by design’ and ‘safer hospital concepts’ which will require all plans be subject of approval by appropriately qualified Welsh Health Estates and local police architectural officers.
• All smaller schemes commissioned by all-Wales employers would be subject to ‘secure by design’ suitability checks.
• All-Wales NHS employers should be encouraged to work with their local community safety partnerships (LHB’s are statutory partners) in tackling crime and anti-social behaviour in Healthcare premises and other areas where healthcare may be provided.

Community staff, facilities and Local Health Board (LHB) staff and premises are equally vulnerable to be exposed to violent and aggressive acts. Whilst all the recommendations of the taskforce are intended to apply universally across the whole NHS-Wales community, special provisions may be required for implementation (time, resource) in such settings.

• Community, Primary Care and LHB provisions should be considered equally with regard to reviewing arrangements and implementing the recommendations. Due to the nature of the environment special timescales, funding and approaches may be required for implementation in these areas.

The recommendations of the Taskforce will have positive impact from implementation only where employers see the benefits and do not have to make choices between their implementation and other competing needs. There are many recommendations which may be implemented soon, with little or no cost and early results. However, some of the recommendations require a more strategic approach and may not realise benefits for several months.
Commitment to full implementation is essential from WAG level to all-Wales NHS Employers and the staff. Resources will be required and failure to provide adequate funding will compromise success.

- WAG must ensure adequate funding (*Capital and revenue*) is made available to ensure compliance with statutory guidance and regulations, development of best practice and implementation of the recommendations.
- It is important that WAG ensure systems are developed to regularly review compliance of all-Wales NHS employers with statutory guidance, recommendations, and development of best practice and implementation of the recommendations.
- WAG should fully endorse an approach to increase the number of prosecutions of perpetrators of violent or aggressive acts against all NHS staff.
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APPENDIX A

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Ian Bellingham - Executive Director, (Conwy & Denbighshire NHS Trust) representing Trust Chief Executives.
Tania Marsden - HR Director. (North West Wales NHS Trust) - representing Trust HR Directors.

Superintendent Simon Clarke. (South Wales Police) – representing the four Welsh Police Forces.
APPENDIX B
MEMORANDUM OF UNDERSTANDING (ACPO)

Memorandum of Understanding
between the
Association of Chief Police Officers (ACPO)
and the
Welsh Assembly Government
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1. **STATEMENT OF INTENT**

1.1. This document records a shared understanding of the common interest between the Welsh Assembly Government as it applies to the NHS in Wales and the Association of Chief Police Officers (ACPO) relating to the four Welsh Police Forces in prevention, detection and investigation work and application of sanctions in respect of security matters within the NHS.

1.2. It provides a framework for the exchange of information to achieve this and is intended to facilitate good working relationships between all parties and develop clear lines of communication. It establishes guidelines to:

- facilitate effective lines of communication by promoting clear understanding of the Welsh Assembly Government, the NHS in Wales and police responsibilities, working procedures and respective legal constraints
- assist the police and the NHS health body Lead Director to co-operate at an operational level
- facilitate effective exchange of information, investigation of offences and joint working practices with the objective of maximising the prevention and detection opportunities for all forms of crime against NHS staff and property.

1.3. This Memorandum of Understanding (MoU) does not cover fraud work. There is a separate MoU between ACPO and the NHS Counter Fraud Service for that work.

2. **INTRODUCTION**

2.1. It is recognised that assaults on NHS staff are unacceptable. Lord Irvine, in an address to magistrates, stated that:

“The criminal justice system needs to act as an effective deterrent for those who might consider attacking NHS staff”.

2.2. Theft of and damage to NHS property is also unacceptable; every occasion when this occurs involves financial loss to the NHS, diverting funds from their intended purpose of patient care and impacting on the ability of health bodies to provide healthcare services.

2.3. The Welsh Assembly Government fully supports the work of the police in tackling offences in relation to the illegal use and supply of controlled drugs and will work with the police to address illegal use of drugs where this impacts on healthcare delivery.
2.4. In an organisation which is the largest employer in Wales, the development of a proactive working relationship with the police in relation to security matters is essential.

3. **BACKGROUND**

3.1. In 2002 the Welsh Assembly Government issued two Welsh Health Circulars to the NHS in Wales in which it described the measures which needed to be taken to manage the risks of violence and abuse to staff working in the NHS in Wales. In September 2004 the Welsh Assembly Government issued the All Wales Violence and Aggression Training Passport and Information Scheme and in July 2005 it launched its Security Management Framework for NHS Trusts in Wales. These documents provide standards which the NHS in Wales should achieve to manage the risks of violence and abuse to its staff.

3.2. The aim of the Welsh Assembly Government is to ensure that ‘anyone who enters a NHS hospital in Wales should be able to feel safe from violence and abuse, both verbal and physical, and should be able to feel that their personal belongings are safe’\(^2\). The remit of the Welsh Assembly Government does not extend to patients or visitors, although it is acknowledged that a duty of care is owed to these groups and, in particular, the young and vulnerable.

3.3. The current priority areas of action for the Welsh Assembly Government are:

- tackling violence against staff and professionals working in the NHS
- ensuring the security of maternity and paediatric wards.

3.4. In addition to the above, the Welsh Assembly Government strategy is to work both proactively and reactively to tackle violence and aggression issues across the NHS in Wales through a range of generic actions:

- Creating a pro-safety culture
- Deterring those who may be minded to become violent or aggressive
- Preventing incidents of violence and aggression from occurring
- Promoting staff to report incidents of violence and aggression
- Investigating incidents of violence and aggression
- Applying sanctions against those responsible for causing violence and aggression against NHS Wales staff
- Seeking redress through criminal and civil justice systems from those responsible for causing incidents of violence and aggression against NHS Wales’s staff.
3.5. Welsh Health Legal Services provides legal services and support in relation to violence and aggression against staff employed in the NHS in Wales. Welsh Health Legal Services will work with healthcare bodies, the police and the Crown Prosecution Service (CPS) to increase the rate of prosecutions and to provide cost-effective advice on available sanctions against individuals who are violent or verbally abusive towards NHS staff and professionals. In order for Welsh Health Legal Services to comply with its legal obligations, it will be necessary for it to co-operate closely with the police.

4. HEALTH BODY LEAD DIRECTOR

4.1. A key part to the success of this MoU is the requirement for a Health Body Lead Director within each health body. The responsibility of the Lead Director is to promote and lead on security matters at board level.

4.2. The day to day activity for the management of the risks of violence and aggression can be delegated within the health body. The delegated role is to ensure that security management work is delivered locally, but to consistent high standards across the NHS, defined within the national security framework.

5. TRUST/POLICE CONTACT POINTS/LIAISON

5.1. ACPO will ensure that all four police forces in Wales designate a divisional/area single point of contact (SPOC) at strategic, divisional and operational level to facilitate good working relationships with NHS health bodies in their force area. At a strategic level, this would normally be the ACPO officer with responsibility for operational matters. On a more local basis, the Commander at Division, Operational Command Unit (OCU) or Basic Command Unit (BCU) will be the point of contact with the individual health body. (This contact will be referred to throughout this document as the local commander).

5.2. The Health Body Lead Director (or their delegated manager) will be the first liaison point and, in principle, the SPOC or lead at an operational police level in matters of security at a health body, both day-to-day and post-incident.

5.3. An appropriate designated police officer should be invited to attend security meetings within the health body.

5.4. The Health Body Lead Director (or their delegated manager) will be the SPOC within the health body at a commander level, when dealing with security matters.

5.5. Regular liaison through the nominated routes will:
- provide a consistent approach
- encourage liaison
- maintain effective contact in specific cases
- allow for advice or guidance to be given in relation to specific cases
- enable discussions about the levels of involvement of the organisations involved
- provide an avenue for the provision of mutual NHS and police expertise and access to appropriate channels of information
- enable Welsh Health Legal Services to be kept informed of progress of cases being investigated by the police
- ensure that a national standard approach is adhered to
- develop the concept of mutual support in tackling crime within the NHS

6. **POLICE/LEAD DIRECTOR RESPONSE TO INCIDENTS**

6.1. It is recognised that each police force follows its own procedures for incident grading and response. Police forces should ensure that an appropriate response is given to NHS health bodies, taking account of the information provided, and share with the health body the local force policy on incident grading. The police should take account of the clinical condition of an assailant in making any decision to arrest.

6.1.1. **Incidents of violence** – to be treated as a priority where appropriate. Offenders should not be considered eligible for a caution or fixed penalty fine. Particular priority should be given to cases where an assailant has been detained.

6.1.2. **Theft of or damage to NHS property and assets** – standard response expected in line with force incident grading procedure.

6.1.3. **Drug/alcohol-related incidents** – an appropriate response in line with the force policy (also see section 21).

6.1.4. **Paediatric and maternity** – incidents of infant abduction and issues of child protection to be treated as a priority. Health bodies with maternity units are required to carry out abduction drills, assessing and documenting results. It is recommended that abduction drills are conducted in close liaison with the local police force(s).

6.2. The Health Body Lead Director (or their delegated manager) will ensure that all crime that affects the health body, its staff or those service-users (patients) for whom they had a duty of care, or that is committed on health body premises and brought to their attention, is reported to the police.

6.3. The Health Body Lead Director (or their delegated manager) and police will liaise and share information on crime and crime-reporting where it relates to NHS staff or property.

6.4. The police will respond where possible to non-criminal security breaches e.g. trespass at a health body premises. It is recognised that the police have no
powers to deal with these issues and that a response to such calls may be a low priority.

7. **LEGAL ISSUES**

7.1. The legal frameworks for sharing information for the purpose of criminal investigation are shown at Appendix 1.

7.2. The Crime and Disorder Act places responsibilities on some health bodies to participate in crime and disorder reduction partnerships. The Health Body Lead Director (or their delegated manager) should be invited to attend community partnership working groups which relate to tackling violence and crime reduction in the area in which the health body is located.

7.3. Responsibilities under Section 136 of the Mental Health Act 1983 define and agree a place of safety for persons detained under this Act. All health bodies and police forces should negotiate and develop appropriate local policy to meet the requirements of this legislation, including the designated place of safety.

7.4. There is a legal requirement for the police to be involved in an order to execute a Section 135 warrant under the Mental Health Act 1983. The request for police assistance is the responsibility of the Approved Social Worker (ASW) and will be based on risk assessment. If a patient under section of the Mental Health Act 1983 is missing and found to be staying at other premises and is refusing to return to the ward, it is the responsibility of the hospital to obtain a Section 135(2) warrant, which will enable the patient to be taken from the premises (using proportionate force if necessary) and returned to the ward. Local policies must indicate the procedure for sharing risk-related information in order to obtain police assistance.

8. **INVESTIGATION**

8.1. It is the responsibility of the police to investigate criminal activity within the community; however, the Health Body Lead Director (or their delegated manager) will provide support as required to the police during investigations which involve crime in an NHS healthcare setting.

8.2. Part of the role of the Health Body Lead Director (or their delegated manager) is to pursue investigations into security-related matters and incidents involving violence against NHS staff. This includes pursuing a range of sanctions against offenders – in particular, where the incident could be considered low-level crime, such as common assault. Where the police do not undertake a criminal investigation for whatever reason the Trust may wish to involve Welsh Health Legal Services to enable them to progress an investigation into a criminal matter, this should be with the full knowledge
and support of the Health Body Lead Director (or their delegated manager) and the local police force. It is the intention that, where Welsh Health Legal Services are involved, they will investigate all cases of assault on staff up to Actual Bodily Harm, where the police have not already arrested or charged a person(s) for relevant offences connected to that incident.

8.3. The Health Body Lead Director (or their delegated manager) will undertake, manage or oversee investigation work on behalf of the NHS health body in relation to security matters including violence against NHS staff. They will act as a liaison point with the local police to ensure that all such incidents can be properly investigated, that evidence is provided to support the identification and prosecution of offenders and that the recurrence of incidents is prevented.

8.4. Where the Health Body Lead Director’s (or their delegated manager) investigation uncovers a criminal matter, it is recognised that policing priorities may impact on the ability of the local police force to progress such an investigation. The Health Body Lead Director (or their delegated manager), with the support of Welsh Health Legal Services, will progress these investigations where they consider it necessary, with the full knowledge of the police.

8.5. All criminal investigations undertaken by the Health Body Lead Director (or their delegated manager) will be carried out in compliance with the Police and Criminal Evidence Act 1984 (PACE), the Criminal Procedure and Investigations Act 1996, the Regulation of Investigatory Powers Act 2000 (RIPA), Secretary of State Directions and all relevant Codes of Practice and in recognition of the overriding considerations of the European Convention on Human Rights (ECHR).

8.6. Where appropriate, Welsh Health Legal Services will support investigations conducted by the Health Body Lead Director (or their delegated manager) and provide legal guidance during the process.

8.7. Where investigation of criminal offences may impact upon NHS service delivery, patient care will always be a factor in deciding on appropriate action and should be balanced with the needs of the investigation. Where an investigation requires the seizure of NHS properly or the non-use of an area of NHS property, liaison must take place between the Health Body Lead Director (or their delegated manager) and the commander of the local policing area to ensure that patient care is the priority and that evidence is protected and preserved wherever possible.

8.8. Welsh Health Legal Services will provide guidance to the health body on protecting a scene of crime and, when available, will be responsible for assisting with this process as required.
8.9. Welsh Health Legal Services and the NHS health body will always consider each case on its merits in relation to sanctions. The NHS will not necessarily wait for the outcome of criminal or civil proceedings before taking disciplinary action in cases where this action will protect NHS staff and property. Care will always be taken, when undertaking parallel sanctions, not to compromise any criminal investigation.

9. PROSECUTION POLICY

9.1. It is the responsibility of the police to investigate suspected or alleged criminal offences and it is the responsibility of the Crown Prosecution Service (CPS) to deal with prosecution of offenders on behalf of the crown. Where action is not taken by the police, Welsh Health Legal Services may pursue a case, as the policy of Welsh Health Legal Services is to consider prosecution in all cases of violence against NHS staff. Where sufficient evidence exists to pursue prosecution, it is the intention of Welsh Health Legal Services to support the police in progressing these cases or to undertake private criminal prosecutions.

9.2. The police will progress all cases of violence against NHS staff and will not formally caution assailants. All cases will be passed to the CPS for charging decisions.

9.3. Violence against NHS staff is unacceptable and, when this occurs whilst staff are undertaking their duties, it should be considered an aggravating factor to the offence as laid down by the code for crown prosecutors. Aggravating factors include, for example, offences committed:

- on hospital/medical premises
- when the victim is serving the public

For sentencing purposes, it is essential that the case officer, whether that is a police officer or the Health Body Lead Director (or their delegated manager), includes in the case summary the fact that the NHS member of staff was on duty or that the incident was linked to their role within the NHS. The impact of the offence on the resources available for the delivery of NHS care – such as the need for replacement staff because someone has been injured, or cancelled treatments resulting from an assault, theft or criminal damage – should also be recorded in the case summary. Where such information is available, claims for compensation should be made to the court to help demonstrate the financial costs of such criminal activity.

9.4. Professional responsibilities and/or the clinical needs of a service-user (patient) may require that continued contact between the service-user (patient) and member of NHS staff is unavoidable during the investigation process. In such circumstances, the case officer must ensure that the reasons for continued contact are clearly highlighted in the case summary. If, at any
point, it is considered that continued contact will affect the prosecution process, the NHS health body must be promptly notified by the investigating officer and appropriate action taken by the clinical team.

9.5. In addition to investigating offences of violence, it is the responsibility of the police and the policy of the Welsh Assembly Government to pursue prosecution for other criminal offences, e.g. theft, burglary, damage and arson relating to NHS property, with a view to instigating sanctions and seeking redress. In appropriate circumstances, where the police are unable to progress such investigations, the Health Body Lead Director (or their delegated manager) may undertake the investigation, subject to legal advice from Welsh Health Legal Services.

10. **REFERRAL OF CASES TO THE POLICE**

10.1. Where cases are progressed by the Health Body Lead Director (or their delegated manager), early contact should be made with the police if police involvement is likely (e.g. powers of arrest or search are needed). If there is sufficient evidence to substantiate a criminal allegation, this should be presented to the police for progression to arrest. The referral should be made in the form of an evidential package. The evidential package should generally contain the following:

- a chronological summary of the allegations
- full name(s) and personal details (where known)
- all available details of any other parties suspected or involvement in the alleged offences, including reasons for those suspicions.

It should also contain full details of investigations already undertaken:

- full details of all witnesses
- copies of all witness statements
- copies of all documentary exhibits and lists
- a schedule of all other relevant information
- the name and contact details of the Health Body Lead Director (or their delegated manager) with responsibility for the case
- the name and details of the Welsh Health Legal Services contact dealing with the case.

The handover of investigation material should always be to the SPOC at a senior local commander level within the local police force and agreements on the process of handover in such cases should be made at a local policing level.

10.2. Original documentation will be provided to the police on acceptance of a case for investigation/progression. The NHS health body will retain a copy file.
10.3. Where Welsh Health Legal Services has reason to proceed with a case that is not being progressed by the police, the police will return all original case files, papers and exhibits to the NHS health body.

10.4. Where a police investigation is not taken forward for prosecution, Welsh Health Legal Services will review the case and may progress it through private criminal or civil proceedings, in conjunction with the NHS health body. In these circumstances, Welsh Health Legal Services will need to review all the case papers in order for an appropriate decision to be made. There may be occasions when certain relevant case papers, statements and other materials are in the possession of the police or the CPS; a request by Welsh Health Legal Services or the Health Body Lead Director (or their delegated manager) will be required for the release of those items. The police will deal with any requests for case papers, statements and other materials promptly and in line with statutory and common law privacy legislation and current guidance.

10.5. In most cases progressed by Welsh Health Legal Services, consent will have been obtained for the release of a statement and exhibits referred to in it. Where this is not the case, the police should do the following when dealing with the third party disclosure:

- contact the witness, explaining that their statement has been requested*
- ask the witness if they have any objections to the third party disclosure
- provide the third party with the witness’s address and details, provided that the witness has no objections to these details being provided and wishes to communicate with the third party
- advise a witness who refused to consent to the disclosure of a witness statement or address that their refusal may in certain circumstances be overruled, if disclosure is required in the interests of justice (this should be done with appropriate legal advice)
- exercise discretion as to whether or not to disclose the statement if the witness cannot be traced or contacted

*Where it is not appropriate for the police to contact the witness directly, the party seeking disclosure should be invited to send a letter to the witness via the police, who can then forward this to the witness with accompanying CPS advice where necessary.

10.6. If a member of NHS staff suffers injuries as a result of a violent crime, they may wish to pursue legal action to claim compensation. Under Section 33(2) of the Supreme Court Act 1981, a potential plaintiff in an action in respect of personal injuries or an actual plaintiff in such a case (Section 34) may apply for the disclosure of any document ‘relevant to an issue arising or likely to arise out of the claim’. These provisions have now been incorporated into the Civil Procedural Rules. Where a request for the supply of witness statements and other relevant documents in respect of criminal proceedings has been made, to which Sections 33-35 of the Supreme Court Act apply, such requests
should be complied with by the police unless there is reason to believe that disclosure would be injurious to the public interest.

11. **PROVISION OF STATEMENTS OF EVIDENCE**

11.1. The police will normally be responsible for obtaining statements of evidence in all criminal cases involving NHS staff and property, unless agreement is reached that the Health Body Lead Director (or their delegated manager) will obtain statements.

11.2. Where necessary, the Health Body Lead Director (or their delegated manager) can help the officer in the case to obtain witness statements by arranging contact between the officer in the case and the relevant NHS member of staff.

11.3. Where the police are unable to progress a criminal investigation relating to offences involving NHS staff and property, the Health Body Lead Director (or their delegated manager) may conduct an investigation and obtain statements of evidence as required for that investigation and to support private criminal or civil proceedings undertaken by Welsh Health Legal Services.

11.4. Where the police require statements from clinical staff in relation to a service-user (patient), the Health Body Lead Director (or their delegated manager) will help the officer in the case obtain those statements.

12. **PROTOCOLS FOR EVIDENCE-GATHERING**

12.1. Preservation of evidence at the scene of a crime will always be secondary to the preservation of life. Both the NHS staff and the police must undertake a co-operative approach to ensure that the requirements of both parties are met. Where the protection of a scene of serious crime is required and this has a serious impact on healthcare provision, the decision on how to progress should be made jointly between the local commander and the Health Body Lead Director (or their delegated manager).

12.2. The Health Body Lead Director (or their delegated manager) and Welsh Health Legal Services will provide support and guidance to NHS staff on the requirements of protecting a scene of crime and will gather information for police in relation to who was present at the time of the offence, in order to help the officer in the case obtain witness statements.
13. **EXCHANGE OF INFORMATION**

13.1. All Health Body Lead Directors (or their delegated managers) are permitted to supply non-personal data and information to the police. The Health Body Lead Director (or their delegated manager) will ensure that all crime is reported to the police where it affects the health body, its staff or those service-user (patients) for whom they have a duty of care, or where it is committed on health body premises and brought to their attention.

13.2. Regular meetings between the police and health body should take place – the Health Body Lead Director (or their delegated manager) will meet on a regular basis with their counterparts in the local police force(s). The Health Body Lead Director (or their delegated manager) should meet with the local inspector, beat officer and with the local commander. Meeting frequency and schedules should be agreed at local level.

13.3. Post-incident reviews should take place. The Health Body Lead Director (or their delegated manager) and the officer in the case should ensure that a post-incident review is conducted for all serious incidents involving the police. Procedures to facilitate this should be agreed at local level. Reviews should be conducted with a view to establishing good practice and identifying areas of failure in process or procedure.

13.4. Disclosure of urgent information should comply with legislation and should be facilitated where it is in the public interest.

13.5. It is recommended that crime statistics relating to health body premises are made available by the police for review at meetings between the health body and the police, to facilitate discussions about effective local strategies for tackling crime.

13.6. Protocols for any exchange of information should be agreed based on a formal written system, with the exception of emergency situations (see Appendix 1).

14. **NOTIFICATION OF PROCEEDINGS**

14.1. The police officer in the case will notify the Health Body Lead Director (or their delegated manager) of the progress and outcome of all investigations involving NHS staff or property.

15. **COURT APPEARANCES**

15.1. The Health Body Lead Director (or their delegated manager) will ensure that support is provided to NHS staff who are victims of or witnesses to a crime within their health body when a case is progressed to court. This support will be through personal contact with the individual’s line manager, liaison
with human resources, occupational health and welfare departments and victim and witness support services.

16. **POWERS TO ARREST AND DETAIN**

16.1. NHS staff have powers to make arrests under common law, Section 3 of the Criminal Law Act (1967) and Section 100 of the Serious and Organised Crime and Police Act 2005 and powers to detain under the Mental Health Act (1983) and the Mental Capacity Act (2005). All NHS staff should be advised not to exercise their citizens’ power of arrest during the course of their normal business duties, with the exception of those staff specifically trained to do so, e.g. security officers.

17. **POWERS TO RESTRAIN**

17.1. **The Law**

17.1.1. In all cases, the clinical needs of the service-user (patient) and others must be taken into account. Any forcible intervention must be considered absolutely necessary on the basis of risk assessment and must be proportionate to the perceived or actual harm likely to result if no such intervention is made.

17.1.2. NHS staff have a duty of care to protect the public and a responsibility under health and safety legislation to maintain a safe environment. The Human Rights Act (Article 2:1) indicates a positive obligation to preserve life and Article 2:2 allows the use of no more force than is absolutely necessary. Section 3 of the Criminal Law Act 1967 and common law allow all citizens the right to use force that is reasonable to defend themselves or others or to prevent the recurrence of a crime. Restraint may be necessary in all such circumstances.

17.1.3. NHS staff must consider the best interests of the service-user (patient). Staff may be required to use the common law doctrine of necessity to prevent damage to property or harm to themselves, the service-user (patient) or others. The proportionate use of reasonable force may be required in such circumstances.

17.2. **Mental health issues**

17.2.1. NHS staff may be required to restrain a service-user (patient) under statutory authority, e.g. the Mental Health Act 1983, Mental Capacity Act 2005, Children’s Act 1989, compulsory care or treatment orders – in such circumstances, the force used must be absolutely necessary and proportionate to the perceived or actual threat of harm to the service-user (patient), staff or others.
17.2.2. NHS staff must only use a forceful intervention if alternative action or inaction would result in a greater risk. Local joint working protocols must be in place to allow prompt police support when required.

17.2.3. The role of security personnel with regard to use of force must be clearly defined in local joint working protocols.

17.2.4. Police will not restrain service-users (patients) for the purpose of clinical intervention, e.g. enforced administration of medication. Police will attend and intervene to prevent a breach of the peace or to prevent a crime.

17.3. **Use of incapacitant spray**

17.3.1. In exceptional circumstances, incapacitant spray may be used on NHS premises. The decision to use incapacitant spray will be at the discretion of the officer, based on risk assessment.

17.3.2. Where it is necessary to use incapacitant spray on NHS premises, the police will ensure that guidance on decontamination is provided to all NHS staff affected. In the event of the use of an incapacitant spray, the officer should issue a clear verbal warning to persons in the vicinity to minimise the risk of contamination and the officer should guide NHS staff through the decontamination process.

17.3.3. Where an incapacitant spray has been used and the affected person is being transferred by ambulance, police must inform the ambulance staff and provide advice on decontamination procedures.

17.3.4. Where an incapacitant spray has been used and the affected person is being brought to NHS premises, advance warning should be given by the police to the receiving health body whenever possible.

17.4. **Communication**

17.4.1. When possible, notice should be given by the police that they are bringing an individual who is in police custody to an NHS health body for treatment. NHS staff should give consideration to the need for prompt treatment based on clinical need and risk assessment.

17.4.2. In the event that the person in police custody is handcuffed for security or personal safety reasons, handcuffs should only be removed with mutual consent of clinical staff and the escorting officer, based on clinical need and risk assessment.

17.4.3. Persons in police custody should not be routinely de-arrested in NHS premises. De-arrest should only be considered in consultation with the NHS staff if the person has a specific clinical need or is admitted as an in-patient, and the decision should be based on risk assessment.
17.5. **Use of restraint devices**

17.5.1. In exceptional circumstances, some NHS staff may use handcuffs or restraining belts to safely manage service-users (patient) or others when absolutely necessary. Locally-agreed protocols must be in place to closely monitor and manage such practices.

18. **ENTRY AND SEARCH**

18.1. NHS staff do not have powers to search people, property or premises in connection with alleged criminal offences without the permission of the individual or owner.

18.2. Warrants to search premises for evidence under relevant legislation can be issued by a magistrate or crown court judge where appropriate. A warrant authorises a police officer to enter specified premises and to search for and seize permitted articles as specified in the warrant.

18.3. Such a warrant may authorise specified persons to accompany any police officer who is executing it; these may include the Health Body Lead Director (or their delegated manager) or other NHS staff.

18.4. Section 18 of PACE provides a constable with the power to enter and search premises occupied or controlled by a person who is under arrest for an indictable offence, if they have reasonable grounds for suspecting that there are on the premises other items subject to legal privilege that relate –

   a. to that offence, or
   b. to some other indictable offence which is connected with or similar to that offence.

18.5. This power can only be exercised by a police officer who has been authorised in writing by a police inspector. No Health Body Lead Director (or their delegated manager) or NHS security staff can be authorised to enter with the police under this provision.

18.6. For searching within a mental health setting, please refer to Section 35 of this document.

19. **MISSING PATIENTS**

19.1. The police will respond to reports of missing patients in accordance with national ACPO guidance on the management and investigation of missing persons.
19.2. In the case of missing persons who are detained under the Mental Health Act 1983, the police will deal with these incidents in accordance with national ACPO guidance on the management and investigation of missing persons.

20. **INFANT ABDUCTION FROM NHS PREMISES**

20.1. Where there is any potential for an infant abduction from NHS premises, protocols should be agreed between the health body and the local police and put in place to meet the needs of both parties.

21. **HANDLING OF DRUGS**

21.1. Certain authorised NHS staff, where required as part of their duties, have authority to be in possession of controlled drugs for the purposes of healthcare delivery.

21.2. Otherwise, in accordance with the Misuse of Drugs Act 1971, NHS staff have no authority to be in possession of controlled drugs except when:

- *knowing or suspecting it to be a controlled drug, they take possession of it for the purpose of preventing another from committing or continuing to commit an offence in connection with that drug and, as soon as possible after taking possession of it, take of such steps as are reasonably open to them to destroy the drug or to deliver it into the custody of a person lawfully entitled to take custody of it; or*

- *knowing or suspecting if to be a controlled drug, they take possession of it for the purpose of delivering it into the custody of a person lawfully entitled to take custody of it and, as soon as possible after taking possession of it, take all such steps as are reasonably open to them to deliver it into the custody of such a person.*

21.3. The local police force should enter into a local agreement with the NHS health body on action in relation to disposal of illegal drugs in line with legislation. A local policy should be developed with the police in relation to disposal in line with legislation. Where appropriate and through agreement, a police force may provide NHS health bodies with locked, securely fixed, tamper-proof drugs boxes to which only the police have keys.

21.4. NHS staff who take possession of controlled drugs in the course of their work must ensure that drugs are either handed to an on-duty police officer as soon as possible, or placed within the secure box without delay and the police notified immediately.
22. **HAZARDOUS MATERIALS**

22.1. Some health bodies handle hazardous materials. Within the context of this MoU, hazardous materials are those which have been specifically identified by the Home Office or ACPO as having the potential to be used by terrorists to manufacture improvised chemical, biological, radiological or nuclear devices to be used to attack the civil population.

22.2. The security of such materials is of high importance. Health bodies that possess these types of materials are required to take all reasonable steps to protect them from theft, loss and accidental or criminal damage. Health bodies that handle these materials have nominated safety officers within their specialist discipline, e.g. radiation safety officer or nominated person within microbiology laboratories.

22.3. All police forces have a Counter Terrorist Security Advisor (CTSA) who is qualified to give advice on security requirements concerning these hazardous materials. The CTSA should be the single point of contact for the police on such matters. The Health Body Lead Director (or their delegated manager) should be the single point of contact within health bodies.

22.4. Regular liaison between the nominated single points of contact will:

- ensure that a national standard approach is adhered to
- provide a consistent approach to adoption and improvement of security measures
- provide an avenue for the provision of mutual NHS and police expertise and access to appropriate channels of information
- maintain effective contact in specific cases where there has been a significant breach of security affecting hazardous materials

23. **CRIME AND DISORDER PARTNERSHIPS**

23.1. The police and all NHS health bodies should take a co-operative approach to initiatives in crime reduction by actively participating in crime and disorder partnerships.

24. **PATIENTS ADMITTED TO HOSPITAL WHERE A POLICE PRESENCE IS REQUIRED**

24.1. In cases where a patient who is in custody or requires police protection is admitted as an in-patient, there should be prior consultation between the health body and the senior police officer and action agreed in line with the risk assessment. A joint formal risk assessment by the healthcare body and the police should be carried out in such circumstances, to determine if police protection and/or other security measures are required.
25. **INTELLIGENCE-SHARING**

25.1. It is recommended that the Health Body Lead Director (or their delegated manager) and the local beat officer share intelligence in accordance with agreed protocols and guidance. This should not contravene any other legislation which prohibits data-sharing between police forces and the NHS.

26. **POLICE INVOLVEMENT IN VIOLENT PATIENT SCHEMES**

26.1. The police may become involved, in consultation with their local health body, in supporting the delivery of violent patient schemes and in the sharing of information in line with legislation relating to violent patient registers.

27. **USE OF FIREARMS ON NHS PREMISES**

27.1. The response to any firearms incident on NHS premises will accord with the ACPO manual of guidance on police use of firearms.

28. **MEDIA ISSUES AND RESPONSIBILITIES**

28.1. Where investigations that involve NHS staff, property, premises or service-users (patients) are progressed, neither the police nor the NHS health body will provide a media statement without prior consultation with the other party. Pre-agreed press releases will be issued wherever possible.

29. **SURVEILLANCE**

29.1. Any directed surveillance carried out on NHS premises must comply with RIPA.

29.2. Where practicable, the health body should be consulted when police surveillance operations on their premises are planned, in order to prevent the operation being compromised.

30. **MULTI-AGENCY ISSUES / CRIME REDUCTION PARTNERSHIPS /COMMUNITY SAFETY PARTNERSHIPS/ CHILD PROTECTION**

30.1. There may be a requirement for co-operative working between health bodies, the police and other agencies. Any referrals should be in accordance with
n national policy and the multi-agency public protection arrangements guidance.

31. **DEATH IN A HEALTHCARE SETTING**

31.1. Criminal investigation into alleged cases of negligence where a death has occurred in a healthcare setting will require co-operation and liaison between the police and the health body. Where a death has occurred in a healthcare setting that the police wish or are required to investigate, the initial points of contact should be the Chief Executive Officer of the health body and the local commander or senior investigating officer.

32. **RECONCILIATION OF DISAGREEMENT**

32.1. Any disagreements will normally be resolved amicably at local level. A protocol should be developed for dealing with disputes between police staff and NHS staff. This will normally be at the post-incident stage, where an incident debrief will cover all the relevant issues.

32.2. If issues are not resolved through post-incident debrief, they will be escalated through official channels to either the Health Body Lead Director (or their delegated manager) or local commander.

32.3. Ultimately, the issue could be referred to the ACPO operations lead and the Chief Executive of the health body.

33. **AMBULANCE SERVICE**

33.1. The ambulance service is involved in work as an emergency service which brings NHS ambulance staff into contact with police officers in operational situations and requires close working relationships. It is therefore appropriate that there is mutual understanding and co-operation in an operational environment and that, through liaison, agreements can be reached in relation to operational matters, for example:

- securing premises
- flagging systems for risk addresses
- firearms situations
- managing crime scenes

33.2. Where ambulance staff are required to attend planned police firearms operations, the emergency planning officer or the Health Body Lead Director (or their delegated manager) should be involved in the development of an operational order with the police. Where the security level of the firearms
operation prohibits NHS ambulance staff from being involved, consideration should always be given to information of value and the support that the ambulance service can provide in an operational planning situation. The operational order should include arrangements for communication and meeting points and provide an opportunity for the ambulance service to be involved in post-incident debrief.

33.3. If ambulance service staff become aware of the presence of firearms at a location, they will report the situation to the police immediately if safe to do so.

33.4. If a decision by police to impound ambulance service vehicles or seize equipment or other ambulance service property at the scene of a crime is required, the decision must be made at the Health Body Lead Director (or their delegated manager) and local commander level (See paragraph 8.7).

33.5. The ambulance service covers a wide geographical area which covers all four Welsh police force boundaries. When liaising on how all of the above can best be managed, the aim should be to get co-operation and consistency between all police forces and the Welsh Ambulance Service NHS Trust.

34. **MENTAL HEALTH**

34.1. Criminal law has equal application both inside and outside mental health units. It should be assumed that all mental health service-users (patients) have capacity in law for responsibility for their actions. Such persons should be treated similarly to other persons suspected of having committed or been witness to a criminal offence.

34.2. It is recognised that mental illness may be a negative factor in prosecution. To enable a better-informed prosecution decision to be made, mental health professionals should be prepared to disclose confidential patient information to the police as required.

34.3. Assaults and other acts of violence committed against NHS staff by persons suffering from mental illness may only amount to a common assault; however, positive action against the offender by the police may assist with the future risk management of the individual and therefore the police should seek the views of the consultant in charge or responsible medical officer (RMO)\(^1\) prior to deciding how to deal with the matter and what action to take. This will enable the best treatment and management to be determined. It is also important in maintaining the confidence of NHS staff who work in the mental health environment.

34.4. Some incidents will not require the arrest of the service-user (patient) at the time unless it is necessary for them to be arrested to prevent the incident from

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\(^1\) Responsible medical officer only applies to formally detained patients
continuing or any person from being injured or for the preservation of forensic evidence.

34.5. In cases where the service-user (patient) is not arrested, the police should make arrangements with the Trust for them to be interviewed. The trust should facilitate this process by means of the consultant/responsible medical officer (RMO) assessing the service-user (patient) to determine whether they are fit to undergo this process. The consultant/RMO’s assessment should be forwarded in writing to the police custody officer/forensic medical examiner (i.e. the police doctor). This will assist the police custody officer/forensic medical examiner in deciding whether the service-user (patient) is fit to be detained at a police station.

34.6. To comply with the PACE Codes of Practice, the Trust should arrange for an independent ‘appropriate adult’ to accompany the service-user (patient) when they are to be interviewed by the police and ensure the service-user (patient) has been given the opportunity to have legal representation at the interview.

34.7. If there is sufficient evidence for criminal charges to be preferred, the court may ask the consultant/RMO for a report on the service-user (patient)’s fitness to answer the charges and stand trial.

34.8. Where it is appropriate for the service-user (patient) to remain within the mental health unit whilst investigations continue, there should be close liaison between the police and the clinical team with responsibility for the service-user (patient) to effectively manage the preparation of reports as necessary. Professional responsibilities and/or the clinical needs of the service-user (patient) may mean that continued contact is unavoidable during the investigation process. In such circumstances, the case officer must ensure that the reasons for continued contact are clearly highlighted in the case summary. If at any point it is considered that continued contact will affect the prosecution process, the Trust must be promptly notified by the investigating officer and appropriate action taken by the clinical team.

34.9. Within the mental health and learning disability setting, appropriately trained NHS staff can undertake lawful searches of both service-users (patients) and visitors. However, this must be an action that is both proportionate and justifiable in relation to the assessed risk and for which consent has been sought. The justification for searching will usually be the risk of harm to the individual or others, reasonable grounds for suspecting criminal activity that would compromise the safety of others, e.g. weapons, or a wider social problem, such as a chronic substance misuse problem in the clinical area.

34.10. All mental health and learning disability services should have in place a local policy that relates to all aspects of personal and environmental searching. The policy should include action where consent is denied and it must be based on a necessary and proportionate response to the actual or perceived risk, and support staff who are required to undertake this action. It should also outline
the role of the health body Lead Director in relation to any local agreement with the police service as regards their involvement should a search uncover evidence of serious criminal activity or where a need arises to preserve evidence or to store, return or dispose of any discovered items.

35. **REVIEW OF THIS AGREEMENT**

35.1. This Memorandum of Understanding will be reviewed each year by representatives of the Welsh Assembly Government and the Association of Chief Police Officers and amended if necessary.
APPENDICES

APPENDIX 1 – Exchange of information protocol

APPENDIX 2 – Security in high-security Mental Health Trusts

APPENDIX 3 – Local joint working protocol guidance

APPENDIX 4 – Glossary of terms
APPENDIX 1

Protocol for the exchange of information relating to security matters between the NHS and the police

1. **Objective of the protocol**

   This protocol is intended to facilitate the exchange of data between the Police Service and the National Health Service (NHS) in Wales and Welsh Health Legal Services, to enable them to undertake their duties. It is not intended to provide a conduit for the general provision of NHS data, whether personal or otherwise.

   Personal data relating specifically to medical/clinical records can only be disclosed with the express written permission of the data subject or on the order of the courts.

   Disclosure of data shall only be made in accordance with legislation – this Data Protection Act 1998, ECHR Directives and the Crime and Disorder Act 1998.

2. **Exemption to non-disclosure**

   Disclosure of data may be made where it is for the prevention or detection of crime, or the apprehension or prosecution of offenders, and where failure to disclose would be likely to prejudice those objectives. Disclosure of information will only be made in relation to identified cases and any decision to disclose will be made on a case-by-case basis.

   Any requests for information whose purpose is the prevention or detection of crime should specify as clearly as possible how failure to disclose would prejudice the state objective. The request should make clear:

   - why it is envisaged that the provision of the information would prevent crime and/or
   - why apprehension or prosecution of an offender is necessary to detect a criminal offence and how the information will assist in the investigation, e.g. why proceedings might fail without the information.

   Provision of personal data with the written consent of the person to whom the data refers will be considered.

3. **Use of data**

   Personal data disclosed must be relevant to an investigation and should only be used for the lawful purpose(s) specified in the request and shall not be further processed in a manner incompatible with that purpose.
4. **Data quality**

Information discovered to be inaccurate or inadequate for the purposes will be notified to the data owner who will be responsible for correcting the data and notifying all other recipients of the data who must ensure that the correction is made.

5. **Review and weeding of data**

Retention of disclosed information should be for the minimum period needed to achieve the objective of its disclosure, after which time the data will be returned to the originator or destroyed as agreed.

6. **Security**

Agencies to which data is disclosed under the terms of this protocol must ensure that data is kept secure at all times and that only those persons with a duty to deal with the data for the purpose of the disclosure request are permitted access to it.
Guidelines for the development of a local joint working protocol between a police service and healthcare body

1. Planning

- Identify the partners that need to be involved – police, Local Health Board, Trust, social services and ambulance services.
- Consider the boundaries of each service; is one or more police force required to cover one NHS trust and be involved in the work?
- Agree the purpose of the protocol – what does it set out to achieve?
- Plan to review the purpose on completion of the protocol
- Involve the relevant personnel – for example, senior police officer, local police beat officer, senior trust, social services and ambulance service staff, frontline staff from health and social services
- Agree a process for the protocol development – regular meetings, consultation group and a launch date.
- Agree the implementation and review process.

2. Content

Contents of a protocol will vary from area to area in accordance with the services provided. The following provides guidance on content areas; these should be considered for inclusion in any protocol, but this is not an exhaustive list. The Memorandum of Understanding between the Association of Chief Police Officers (ACPO) and the Welsh Assembly Government (as it applies to NHS Wales) should be referred to when developing the areas relevant to the local service need.

2.1. Introduction

- Identify the background of the protocol.
- Identify the partners involved.
- Provide contact details for all relevant personnel.
- Explain the role of the health body Lead Director and locally agreed arrangements.
- Include frequency and membership of local police liaison meetings.

2.2. Criminal activity

Include action that the police and health body will take in respect of criminal activity in a healthcare setting, for example:
- theft
- damage to property, including arson
- drug-related incidents
- alcohol-related incidents
- harassment
- threats of violence
- assault
- target hardening

Also include:

- the role of the health body Lead Director in the investigation process
- responsibilities in relation to crime scene management and, where appropriate, securing of premises
- the process for reporting crime and the need to follow local and national incident reporting procedures
- the role of Welsh Health Legal Services
- prosecution procedures in mental health and learning disability settings where appropriate

2.3. **Information-sharing**

This should include:

- the process of sharing information to manage risk and pursue prosecution
- the process of sharing intelligence between the local police officer and the health body Lead Director as part of a crime reduction strategy
- the protection and gathering of evidence post-incident
- responsibilities for taking statements
- the process for notification of progress and outcomes of investigations
- arrangements for witness support through the police and the health body Lead Director
- the process of information sharing and systems of ‘flagging’ high-risk addresses where appropriate

2.4. **Restraint**

This should include:

- a clear indication of the roles and responsibilities of health and social care staff and the police in regard to restraint
- guidelines for the use of incapacitant spray, the Tasar and use of firearms
2.5. **Search procedures**

This should include:

- clear identification of the roles and responsibilities of health and social care staff and the police – including searching for drugs and weapons
- where appropriate, arrangements for searching in mental health, learning disability and high-security settings

2.6. **Mental Health Act**

This should include:

- the arrangements for requesting police support in Mental Health Act assessments, including Section 135/2
- procedures for assessment of patients detained by police officers under Section 136.

A proforma for sharing risk-related information between social services, healthcare staff and the police is recommended.

2.7. **Missing persons**

This should include:

- the reporting procedures for missing persons
- the identified actions to be taken in the event of a high-risk missing person who may be a danger to themselves or others
- arrangements for the return of a missing person, including those circumstances where the police may not assist
- defined responsibilities of social care, healthcare and police staff in relation to patients detained under the Mental Health Act
- arrangements for sharing information between agencies regarding escaped prisoners or absconders from secure units.

A proforma for sharing risk-related information between social services, prison services, healthcare staff and the police is recommended.

2.8. **Death in care**

This should include:

- defined procedures for notifying the police of deaths in care
- the identified actions to be taken in the event of a sudden death, and an explanation of the need to preserve evidence
2.9. **Hostage situations**

This should include:

- the identified actions to be taken in the event of a hostage situation.

2.10. **Disturbance**

This should include:

- the identified actions to be taken in the event of serious disturbances/riot situations in a healthcare setting.

2.11. **Major incidents**

This should include:

- the procedure for evacuation of premises where the support of the police and other emergency services is required
- the arrangements for and organisation of emergency planning exercises.

2.12. **Infant abduction**

This should include:

- identified actions to be taken by the police and NHS staff in the event of an infant abduction if the health body has maternity/paediatric services.

2.13. **Handling drugs and hazardous substances**

This should include:

- policies and procedures for handling drugs and hazardous substances.

2.14. **Surveillance**

This should include:

- agreed arrangements to be made when police surveillance is undertaken on health body premises.

2.15. **Press releases**

This should include:

- agreed arrangements to be made when a press release is required
- identification of the process required and the personnel who would collaborate to agree the content of a press release.
2.16. **Training initiatives**

This should include:

- methods of disseminating the content of the protocol to all personnel
- agreement on any shared training initiatives

Training should promote understanding of the roles and responsibilities of the police and healthcare professionals.

2.17. **Reconciliation and review**

This should include:

- procedures for reconciliation
- review date for the protocol.
**APPENDIX 3**

**Glossary of terms**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>BCU</td>
<td>Basic command unit</td>
</tr>
<tr>
<td>CPIA</td>
<td>Criminal Procedure and Investigations Act</td>
</tr>
<tr>
<td>CPS</td>
<td>Crown Prosecution Service</td>
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<tr>
<td>ECHR</td>
<td>European Convention on Human Rights</td>
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<tr>
<td>OCU</td>
<td>Operational Command Unit</td>
</tr>
<tr>
<td>PACE</td>
<td>Police and Criminal Evidence Act 1984</td>
</tr>
<tr>
<td>PEACE</td>
<td>Preparation &amp; planning, engage and explain, account, closure, evaluation</td>
</tr>
<tr>
<td>RMO</td>
<td>Responsible Medical Officer</td>
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Memorandum of Understanding between the Crown Prosecution Service and the Welsh Assembly Government
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PROLOGUE

1. **Introduction**

1.1. This Memorandum of Understanding (‘Memorandum’) has been agreed between the Crown Prosecution Service (‘CPS’) and Welsh Assembly Government to ensure the effective prosecution of cases involving violence and abuse (whether physical, verbal or sexual, and including assaults which are religiously or racially motivated) against any member of ‘NHS staff’ (defined in Secretary of State Directions made under the National Health Service Act 1977 as ‘any person who is employed by or engaged to provide services to an NHS body’).

2. **Scope**

2.1. This agreement will only cover investigations that are referred to the CPS by the police. The CPS will only review investigations by a third party if, at some point, the matter is handed over to the police who then refer it to the CPS. This does not restrict the ability of the Director of Public Prosecutions to take over a private prosecution under section 6(1) Prosecution of Offences Act 1985 (see paragraphs 5.5, 5.6 and 5.7 of the Memorandum).

2.2. References to ‘NHS staff’ mean ‘any person who is employed by or engaged to provide services to an NHS body’ and who is the victim of an assault, public order offence or harassment whilst they are on duty.

2.3. This Memorandum applies to **Wales** as the Welsh Assembly Government has responsibility for security and operational policy in Wales only.

2.4. This Memorandum does not apply to incidents of fraud or corruption in the NHS.

3. **Commencement and amendment**

3.1. This agreement will take effect on **21st March 2007**.

3.2. This agreement may be amended as appropriate at any time if the parties to the Memorandum agree. Any amendments should be agreed in writing. Any amendment must, however, be consistent with the nationally-agreed protocols and standards. It is vital that there is also congruity between England and Wales and this must be considered as part of any amendments.
4. **Nationally-agreed protocols and standards**

4.1. The delivery of local arrangements within the framework of this Memorandum will be consistent with the following protocols and standards:

- Memorandum of Understanding between the Welsh Assembly Government and the Association of Chief Police Officers
- The Code for Crown Prosecutors
- The Director of Public Prosecutions (DPP)’s Guidance on Charging
- The DPP’s Guidance on Conditional Cautioning
- Charging Standards for relevant offences
- CPS Policy statements, including the statement on racially and religiously aggravated crime and homophobic crime
- CPS Public Policy Statement on the Delivery of Service to Victims
- The Farquharson Guidelines on the Roles and Responsibilities of the Prosecution Advocate
- The Bar CPS Standard for Communication between Victim and Witnesses and the Prosecution Advocate
- Welsh Health Legal Services Policy

5. **Local agreements, disputes and monitoring**

5.1. Effect should be given to this protocol locally by a suitable service level agreement between the parties, and any other organisation or bodies that the parties think appropriate.

5.2. Any disagreement over the workings of this protocol of local agreements will be referred to the agreed level of management for early and informal resolution, wherever possible.

5.3. The parties will, at an agreed interval, monitor the workings of this protocol and any local agreements with a view to improving the efficiency and effectiveness of local professional working arrangements.

6. **Revision**

6.1. As explained in paragraph 3.2 above, this Memorandum may be amended at any time. Whether or not any amendments are made, it should be the subject of a thorough and detailed review by both parties by November 2007 (at the same time as NHS England).

6.2. Date of first issue – **21st March 2007**
7. **Contact Details**


7.2. CPS South Wales, Capital Towers, Greyfriars Road, Cardiff

8. **Signatories**

8.1. The signatories agree to implement the provisions of this Memorandum and any arrangements set out in the attached documents.

**For the Crown Prosecution Service**

Name: Sir Ken Macdonald QC, Director of Public Prosecutions

Signature:

Date …..3 April 2007 ……………………………………….

**For the Welsh Assembly Government**

Name: Dr Brian Gibbons AM, Minister for Health and Social Services

Signature:

Date: ………22 March 2007 ………………………………………..
MEMORANDUM OF UNDERSTANDING
BETWEEN
THE CROWN PROSECUTION SERVICE
AND
THE WELSH ASSEMBLY GOVERNMENT

1. Aim

1.1. This Memorandum sets out the agreement between the Welsh Assembly Government and the Crown Prosecution Service (‘CPS’) to secure achievement of the common purpose of the effective prosecution of cases involving violence and abuse (whether physical, verbal, sexual or racial) against any member of ‘NHS staff’ (defined in Secretary of State Directions made under the National Health Service Act 1977 as ‘any person who is employed by or engaged to provide services to an NHS body’).

1.2. The aim of this Memorandum is to foster an effective working partnership between the CPS and the Welsh Assembly Government as it applies to NHS Wales. This relationship will be underpinned by:

- effective and efficient communication, including the exchange of information; and
- the clear understanding of the respective roles, responsibilities, procedures and any legal constraints.

2. Objectives

2.1. The objectives of the Memorandum are:

- to issue a clear statement on prosecution policy which will engender confidence amongst NHS staff
- to set out the roles and obligations of the parties to the Memorandum
- to promote communication and establish the framework for the exchange of information at area level.

3. Background

3.1. NHS staff have an important role within our communities and they must feel safe in the environments they work in. To this end, NHS staff must feel confident that the criminal justice system will afford them the protection that they deserve.
3.2. NHS staff are at greater risk of violence or verbal abuse than many other professionals. This is underlined by recently published Department of Health statistics for 2004-2005:

- one assault for every five staff working in mental health and learning disability services (43,097 incidents in total)
- one assault for every 23 ambulance staff (1,333 incidents)
- one assault for every 65 primary care trust staff (5,192 incidents)
- one assault for every 68 staff working in acute hospitals, including A&E units (10,758 incidents in total).

4. **The Welsh Assembly Government**

The Welsh Assembly Government has overall responsibility for all policy and operational matters related to the management of security and violence and aggression in the NHS in Wales.

4.1. The aim of the Welsh Assembly Government is to ensure that ‘anyone who enters a NHS hospital in Wales should be able to feel safe from violence and abuse, both verbal and physical, and should be able to feel that their personal belongings are safe’\(^2\). The remit of the Welsh Assembly Government does not extend to patients or visitors, although it is acknowledged that a duty of care is owed to these groups and, in particular, the young and vulnerable.

4.2. The current priority areas of action for the Welsh Assembly Government are:

- tackling violence against staff and professionals working in the NHS
- ensuring the security of maternity and paediatric wards.

4.3. In addition to the above, the Welsh Assembly Government strategy is to work both proactively and reactively to tackle violence and aggression issues across the NHS in Wales through a range of generic actions:

1. Creating a pro-safety culture
2. Deterring those who may be minded to become violent or aggressive
3. Preventing incidents of violence and aggression from occurring

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\(^2\) Published on Department of Health website 10 June 2006  
\(^2\) Security Management Framework for NHS Trusts in Wales (July 2005)
4. Promoting staff to report incidents of violence and aggression
5. Investigating incidents of violence and aggression
6. Applying sanctions against those responsible for causing violence and aggression against NHS Wales staff
7. Seeking redress through criminal and civil justice systems from those responsible for causing incidents of violence and aggression against NHS Wales staff.

4.4. The Welsh Assembly Government has put in place a number of measures to help increase the number of prosecutions and to prevent and deter violence against staff:

- The agreement with Welsh Health Legal Services, which provides legal services and support in relation to violence and aggression related matters. Welsh Health Legal Services was established on first April 1996 as part of the Welsh health common services authority and on first April 1999 was merged with Conwy & Denbighshire NHS Trust. It is a unit of 20 in house Solicitors providing a range of a Legal advice & representation exclusively to the NHS in Wales. Welsh Health Legal Services has agreed to work with healthcare bodies, the police and the CPS in order to increase the number of prosecutions (that are legally robust), and to provide cost-effective advice on available sanctions against individuals who are violent or verbally abusive towards NHS staff and professionals. Welsh Health Legal Services with the permission of the NHS body may lawfully pursue private criminal prosecutions and civil litigation on behalf of NHS bodies in relation to assaults and abuse of NHS staff. This power stems from Directions issued by the Secretary of State under the NHS Act 1977. When Welsh Health Legal Services is considering whether to bring a private prosecution, it will apply its internal prosecution policy and adhere to section 5 of the CPS Code for Crown Prosecutors.

- A health body Lead Director to monitor incidents of assault and liaise with the police and CPS to support any investigation and subsequent prosecution, offering assistance and support where necessary. This Director will ensure good liaison with Witness Care Units.

4.5. A joint agreement between the Association of Chief Police Officers (ACPO) in Wales and the Welsh Assembly Government has been published. This agreement:

- provides a framework and guidelines for the investigation of offences against NHS staff
identifies joint working practices which are aimed at preventing crime against NHS staff and property

establishes clear lines of communication and liaison, both nationally and locally

ensures that a response to a particular incident is appropriate.

5. **The Crown Prosecution Service**

5.1. The Crown Prosecution Service (CPS) is the principal public prosecuting authority for England and Wales. Although the CPS works closely with the police, it is independent of them. Casework decisions are taken with fairness, impartiality and integrity that help deliver justice for victims, witnesses, defendants and the public.

5.2. The police are responsible for investigating allegations of crime and for gathering evidence about what occurred. The CPS is responsible for deciding the charge in all but the most minor offences.

5.3. As agreed in the Welsh Assembly Government Memorandum of Understanding with ACPO Wales, the police will progress all cases of violence and abuse against NHS staff as a priority. The CPS will work with the police to ensure that these cases are treated with the seriousness that they deserve and encourage a robust charging policy to be applied by prosecutors.

5.4. When the CPS has decided not to charge, or discontinued or recommended a caution or a conditional caution for an assault against a member of NHS staff, Welsh Health Legal Services may consider a private criminal prosecution or issue civil proceedings against the perpetrator. Where this action is considered Welsh Health Legal Services will follow its internal prosecution policy and adhere to section 5 of the CPS Code for Crown Prosecutors.

5.5. The CPS has a discretionary power under section 6(2) Prosecution of Offences Act 1985 to take over criminal proceedings instituted by or on behalf of private individuals, and then discontinue. This will only be done when there is a particular need to do so on behalf of the public. An example would be a malicious prosecution or a prosecution that may interfere with the investigation of another criminal offence. The decision to take over proceedings can only be given by a Chief Crown Prosecutor, London Sector Director or one of the Directors of Organised Crime, Counter Terrorism or Special Crime.

5.6. If the CPS receives a request to take over a private prosecution conducted by Welsh Health Legal Services, the Chief Crown Prosecutor, London Sector Director or Directors of HQ Casework, or a
prosecutor appointed by such a person, will contact Welsh Health Legal Services in order to facilitate discussion with the relevant person before any such decision is taken. This contact will include sending relevant documentation that the CPS may have received from the requestor (such as medical expert reports on the defendant) in order to facilitate a meaningful dialogue. The third party will be informed by the CPS that this will be done and that the information contained therein will remain confidential.

5.7. The CPS will only take over a private prosecution brought by Welsh Health Legal Services if it is apparent that it has disregarded or misapplied its own internal prosecution policy and/or section 5 of the CPS Code for Crown Prosecutors. An example may be where there is clearly no case to answer or where the public interest is plainly against prosecution.

5.8. When, as a result of the referral of a case by the police to the CPS, a person has been conditionally cautioned and has successfully completed the requirements placed upon him or her by the prosecutor, there will be a presumption that a private prosecution in relation to the same offence is not in the public interest. This presumption may be rebutted in exceptional circumstances, following discussions between the CPS and Welsh Health Legal Services.

5.9. Further reference should be made to the CPS Legal Guidance chapters on Private Prosecutions and Relations with other Prosecuting Authorities (available at www.cps.gov.uk)

6. The Code for Crown Prosecutors and Prosecution Policy

6.1. All cases are reviewed by CPS prosecutors in accordance with the tests as set out in The Code for Crown Prosecutors. Prosecutors make charging decisions in line with the Full Code Test, other than in limited circumstances where the narrower Threshold Test applies.

The Full Code Test

6.2. The Full Code Test has two stages. The first stage is consideration of the evidence. If the case does not pass the evidential stage, it must not go ahead, no matter how important or serious it may be. If the case does pass the evidential test, prosecutors proceed to the second stage and decide if a prosecution is needed in the public interest.

The first stage – the evidential stage

6.3. Prosecutors must be satisfied that there is enough evidence to provide a realistic prospect of conviction for each defendant on each charge. This means that a jury or a bench of magistrates or a judge hearing the
case alone, properly directed in accordance with the law, is more likely than not to convict the defendant of the charge alleged.

The second stage – the public interest test

6.4. If the case does pass the evidential test, prosecutors must then decide whether a prosecution is needed in the public interest. A prosecution will usually take place unless there are public interest factors tending against prosecution which clearly outweigh those tending in favour.

6.5. Paragraph 5.9 of the current Code for Crown Prosecutors provides that ‘a prosecution is likely to be in the public interest if the offence was committed against a person serving the public’.

The Threshold Test

6.6. The Threshold Test requires prosecutors to decide whether there is a reasonable suspicion that the suspect has committed an offence and, if there is, whether it is in the public interest to charge the suspect. This test is applied in those cases when it would not be appropriate to release a suspect on bail after charge, but the evidence to apply the Full Code Test is not available. The Threshold Test can only be applied if it is reasonably anticipated that such evidence or information will shortly be available.

6.7. The Full Code Test must be applied as soon as reasonably practicable after charge and a review date will be set by the prosecutor. This is the date by when the necessary information must be received and the Full Code Test applied.

Application of the Code to physical and verbal abuse against NHS staff

6.8. Subject to the application of section 8 below, the CPS will robustly and fairly prosecute offences of violence or abuse that are committed against NHS staff. This Memorandum will apply when a person is assaulted whilst either on duty or off duty if the victim is being targeted because of their work.

6.9. The abuse suffered may be physical, verbal or sexual, and it may be religiously or racially motivated.

6.10. The Code for Crown Prosecutors gives a clear indication of the strong public interest in prosecuting such violence as long as the evidential sufficiency test is met. Drink and drug abuse will not be regarded as valid mitigation but rather it will be treated as an aggravating feature. A further aggravating feature prosecutors should consider is the potential harm to others if the assault may result in the withdrawal of medical services to those in need of attention. For example, the
withdrawal of an ambulance crew or Accident and Emergency clinical staff.

6.11. This Memorandum does not remove the need for each case to be considered on its own individual merits or fetter the discretion to prosecute the most appropriate offence depending on the particular facts of the case.
7. **Charging standards**

7.1. The CPS and police publish joint ‘charging standards’ for certain offence types to ensure that the most appropriate charge is selected at the earliest opportunity. Assaults against the person and public order offences are covered by their own individual charging standards.

7.2. The ‘Assaults against the person’ charging standard reminds prosecutors of the provisions of paragraph 5.9d of The Code for Crown Prosecutors (see 6.5 above), which indicates that a prosecution is likely to be in the public interest if the offence is committed against those who serve the public. The charging standard provides examples of ‘public servants’ and refers to doctors and nurses. This principle expands to include all NHS staff (as defined above) and all offences committed against them, and not merely assaults.

7.3. Prosecutors should pay particular attention to paragraph 1 (viii) of the ‘assaults against the person’ charging standard when reviewing a case that involves an assault on an NHS staff members when the injuries are consistent with a charge of common assault. This paragraph provides that even when the injuries suffered are typical of common assault, the more serious charge of assault occasioning actual bodily harm may be more appropriate if there are ‘aggravating features’. Such an aggravating feature may be the vulnerability of a victim who has to work with the public or in the community.

8. **Diversion from prosecution**

8.1. When reviewing a case, prosecutors may consider alternatives to prosecution where appropriate. This may arise when the prosecutor decides that while the public interest justifies a prosecution, the interests of the victim, the community and the suspect are better served by an alternative to the formal court process. For adults, this might include a simple or conditional caution.

8.2. A simple caution is a formal warning that is given by or on the instructions of a senior police officer. A prosecutor can recommend that a suspect is cautioned for an offence. A conditional caution is similar to a simple caution, except that the public interest is best served by the offender carrying out specified conditions attached to the conditional caution rather than being prosecuted. If an offender fails to comply with any of the conditions, he/she may be prosecuted for the original offence. Conditional cautions are administered by police officers on the advice of a prosecutor. They are only available for adult offenders.
8.3. When considering whether to recommend that an offender be cautioned, prosecutors will have regard to Home Office Circular 30/2005 which reminds police officers that an offence with aggravating features is likely to be deemed unsuitable for caution (paragraph 8).

8.4. If a caution or conditional caution is being considered, prosecutors will ensure that the police will obtain or have obtained the views of the victim, unless there are exceptional circumstances which make this impractical. An exceptional circumstance may be when the victim has proved to be uncontactable and the matter can no longer be delayed. This is in accordance with paragraph 11 of HOC 30/2005 and part 7 of the Code of Practice for Conditional Cautioning. These sections reiterate the importance of establishing the victim’s views prior to the decision on cautioning and of taking these views into consideration when determining whether it is right in all the circumstances to offer a caution to the offender.

8.5. Where a caution or conditional caution is considered the most suitable method of disposal by the CPS, the offender will be informed that the caution is not a bar to the victim or Welsh Health Legal Services instituting civil or criminal proceedings against that person. Such a notification will normally be achieved by the caution administering officer using the standard form of words which contains a warning about the potential for future proceedings, and the circumstances in which the caution is administered must be fully documented.

9. **Welsh Assembly Government support for CPS prosecution**

9.1. To support a criminal prosecution, the CPS and police are likely to require evidence from NHS staff (and possibly patients), including medical reports, where appropriate, relating to the examination and treatment of the victim for any injuries sustained. The police gather evidence and will notify the NHS health body Lead Director in accordance with the WAG/ACPO (Wales) Memorandum of Understanding.

9.2. If problems are encountered in obtaining relevant information from NHS bodies which may potentially jeopardise a prosecution, the NHS health body Lead Director should be promptly notified. The NHS health body Lead Director will then liaise with the CPS, police and the relevant health body to ensure that requested information is provided as soon as practicable.

9.3. If the requested information is of such fundamental importance that a case cannot be prosecuted without it and if it is reasonable for such evidence or information to be obtained, the CPS will request that the police take such steps as are thought reasonable and necessary to
obtain the evidence or information before discontinuing the criminal prosecution.

9.4. When considering a request for evidential information, NHS bodies must bear in mind that the prosecution (whether prosecutors or police officers) must act with all due diligence and expedition. Cases are at risk of being stopped or offenders being released from custody if there is any unreasonable and undue delay in obtaining evidence or relevant information.

9.5. Witness statements from hospital staff will be sought as soon as possible by the police in the preparation of a case. In accordance with the Memorandum of Understanding between the Welsh Assembly Government and ACPO (Wales), the police should ensure that staff who provide witness statements will mark the rear of the statement form with details of their known unavailability (e.g. holidays) to avoid delay and costs. Their preferred method of contact should also be provided on the form.

10. Escalation and appeals

10.1. When requested, because a private prosecution or civil action may be brought, the CPS will provide detailed explanations as to its review decisions in particular cases. Such requests should be made via the relevant NHS health body Lead Director.

10.2. Where there is disagreement between the victim and or the NHS trust on the CPS decision to charge, caution or not to prosecute, or on the level of charge, concerns should be raised with the NHS health body Lead Director. The NHS health body Lead Director will then seek an explanation from the investigating officers, who may contact the Crown prosecutor.

10.3. If any concerns are not satisfied and the investigating officers are unhappy with the CPS decision, the matter must be escalated in accordance with the procedure set out in the Director’s Guidance on Charging (2005).

10.4. In such circumstances, the NHS health body Lead Director shall be informed of discussions and relevant CPS decisions prior to the offender being informed.

11. The decision to prosecute and mentally disordered offenders

11.1. It is recognised that many acts of violence, abuse and threats of violence against NHS staff are committed by those who may be suffering from a mental disorder. ‘Mental disorder’ is defined in the
Mental Health Act 1983 as including mental illness, mental impairment, severe mental impairment and psychopathic disorder.

11.2. Mental disorders vary in nature and degree and the fact that a person has such a disorder is not an automatic bar to prosecution. Similarly, the fact that a person is detained under a section of the Mental Health Act 1983 is also not an automatic bar to prosecution. It is the responsibility of the CPS to consider alternative disposals and to prosecute offenders where it is in the public interest to do so. The CPS, where necessary, applies Home Office guidelines about how to deal with mentally disordered offenders and follows internal legal guidance on definitions and the factors to apply.

11.3. It should be borne in mind that all cases should be reported to the police except in those cases where the NHS health body Lead Director in the health body, having consulted with relevant staff and obtained clinical advice, has reached the conclusion that the assault was not intentional and that the patient did not know what they were doing, or did not know what they were doing was wrong due to the nature of their medical illness, mental ill health or severe learning disability or the medication administered to treat such a condition. This will normally mean that the staff present have formed an initial view that the offender’s behaviour has not arisen as a result of any condition or treatment.

11.4. The Code for Crown Prosecutors provides important guidance to prosecutors when applying the public interest test in cases involving a mentally disordered offender. A factor against prosecution is when a defendant, at the time of the offence, was suffering from significant mental or physical ill health unless the offence is serious and/or there is real possibility that it may be repeated. Prosecutors should also consider whether a prosecution may help a defendant take responsibility for his/her actions.

11.5. Furthermore, the CPS Code for Crown Prosecutors provides that a public interest factor against prosecution is if the court is likely to impose a nominal penalty. Similarly, if an offender is already receiving treatment which a court might subsequently order upon conviction, then careful consideration should be given as to whether to proceed with the prosecution or not. The views of the alleged offender’s responsible medical officer at the health body must also be sought and considered. It is also important to establish the mental health status of the alleged offender who is receiving treatment (for instance, it may be voluntary, under section or as a result of a court order etc). If treatment is likely to be an important factor in the decision to prosecute, the relevant NHS body should be contacted,
through the NHS Lead Director, and asked to provide current information along with any opinion it feels appropriate.

11.6. The existence and treatment of a mental disorder is only one the factors to be taken into account when deciding whether the public interest requires a prosecution. The seriousness or persistence of the relevant behaviour and, importantly, the views of the victim and the offender’s responsible medical officer at the health body must also be considered.

11.7. It is important to understand that the decision to prosecute must be determined on the relevant public interest factor, once the test for evidential sufficiency has been met. The perceived need for the treatment and management of a mental disorder will not be the sole reason why a prosecution is pursued. This should be based on an individual’s needs and the risk she/he poses to himself and others and not on the existence of a prosecution and/or conviction.

11.8. The CPS will need information and evidence regarding the mental disorder at the earliest opportunity in order to properly review a case involving a mentally disordered suspect. This will ensure that appropriate cases are properly progressed and will prevent any arbitrary decisions being taken regarding a person’s mental health or capacity without the decision maker obtaining the fullest information. Such information should include, where appropriate, details regarding the suspect’s capacity at the time of the alleged offence(s), and their fitness to be arrested, detained, interviewed, charged and to plead. Further information should also be requested in relation to whether he or she has acted in a similar manner before, the likelihood of further offences, and the mental health status and treatment of the alleged offender. A prompt response will be required and the NHS health body Lead Director should assist the police and CPS in obtaining the information from the relevant NHS body when required. The CPS should immediately notify the NHS health body Lead Director if it is having difficulty in obtaining any information relevant to its review of the case. Examples of information that may be requested include:

- medical reports from appropriate clinician or responsible medical officers to explain the nature and degree of the disorder and the treatment and behaviour of the patient

- any other relevant information from other hospital staff about the treatment and behaviour of the patient, including the treatment regime, history of similar and recent violent or other offending behaviour

- information about an offender’s status in hospital – whether voluntary or detained under section 2 or section 3 (civil procedures)
or under section 37 (Court Hospital Order) and whether there is a restriction order under section 41 attached to the section 37 order

- evidence from a suitably qualified clinician about the offender’s state of mind at the time the incident took place, including whether the patient knew what they were doing, whether they knew that what they were doing was wrong and, if not, whether the lack of knowledge was attributable to his disorder and/or any medication or other treatment for their disorder

- evidence regarding the person’s fitness to plead.

11.9. Prosecutors may not always be aware from the outset that an offender has a mental disorder, particularly if the offence was committed in or around the Accident and Emergency department of a hospital, or the offender is receiving treatment in another department, hospital or healthcare establishment or in the community. Initial information may come from the custody sergeant or police surgeon in connection with fitness to be detained and/or be interviewed and the need for an appropriate adult to attend. Alternatively, the information may come from defence representatives, court staff or any other person who has had dealings with the suspect. In such cases, there may be an urgent need for medical reports and information to clarify the nature and degree of the mental disorder. These requests should be treated as a priority by the NHS health body Lead Director.
12. **Anti-Social Behaviour Orders (Asbos)**

12.1. When reviewing a case where an NHS staff member has been assaulted, threatened or abused, prosecutors should always consider whether it may be appropriate to apply for an anti-social behaviour order (Asbo) on conviction. There is no qualification in terms of the type of offence, but two tests must be satisfied in order to qualify:

- that the individual has committed an act of anti-social behaviour;

and

- that an order is necessary to protect the NHS or wider public.

12.2. A number of different public bodies may apply for Asbos, in addition to the CPS prosecutor’s power to apply for an Asbo on conviction. It is advisable that the NHS health body Lead Director consult with relevant agencies in the area prior to an Asbo application being forwarded to the CPS in order to ensure that there is a co-ordinated approach to applications and that all relevant evidence is put forward with the application.

12.3. In cases where the CPS applies for a post-conviction Asbo, it is important that appropriate evidence is obtained at the earliest opportunity. The defence must be served with a copy of the papers and notified that an application is pending. Appropriate evidence will include:

- statements from witnesses to the incident
- CCTV imagery
- medical records
- impact of the behaviour on those NHS staff who were subjected to it
- incident reports or other evidence of previous anti-social behaviour

12.4. It is important that the NHS health body Lead Director works closely with the police and CPS to assist their drafting of appropriate conditions to be attached to the Asbo. The full extent of the anti-social behaviour must be covered in draft orders, e.g. harassment, phone calls, threatening behaviour etc.

12.5. After a post-conviction order has been served on a defendant, it will be recorded on the police national computer. The relevant NHS trust(s) should be informed of the making of the order, the prohibitions that it
contains and its expiry date so that they may circulate this information to the relevant health body. Publicity of the order will be a matter for the NHS health body Lead Director and the healthcare establishment. The Home Office Guide to Anti-Social Behaviour Orders\(^3\) provides guidelines on the handling and appropriateness of publicity and these should be followed.

**Breaches and modifying conditions of Asbos**

12.6. In the event of a breach of an Asbo, the NHS health body Lead Director will assist in providing evidence to the police about the behaviour which caused the breach. It will be referred to the CPS for consideration of charge.

12.7. If, during the duration of the order, the subject behaves inappropriately and in such a way as to avoid the conditions of the order, the NHS health body Lead Director should raise this with the CPS, via the police, in order for consideration to be given to vary the Asbo conditions.

12.8. If circumstances change and there is a need to discharge the Asbo, the CPS will apply to the court if there is evidence to support the application, and it is appropriate to do so and all the parties have consented.

**Other orders available on sentencing**

12.9. In some cases, because of either the particular nature of the offending or a focus on a particular individual or organisation, an Asbo will not be appropriate. In such cases, consideration should be given to reminding the court of other avenues available to restrict the offender’s future conduct and offer protection to victims, for example:

- **Criminal Justice Act 2003**
  - Section 203 Prohibited Activity Requirement
  - Section 205 Exclusion Requirement

- **Protection from Harassment Act 1997**
  - Section 5 Restraining Order

12.10. The NHS health body Lead Director should be contacted to ensure that the conditions of such orders offer the protection required while still allowing legitimate access to health services.

13. **Bail and conditions**

\(^{3}\) Published August 2006
13.1. If a suspect or defendant is deemed suitable for bail, it is important that the police and CPS work closely with the NHS health body Lead Director in formulating appropriate conditions to protect the NHS and its staff as promptly as possible. Similar conditions to those used in Asbos might be considered – for example, exclusion orders. Information that is provided must be accurate, current and clear.

13.2. When appropriate, consideration should be given to including a condition that if the suspect needs to attend hospital for genuine emergency treatment, they will not be excluded under the terms of their bail.

13.3. If a suspect is released on bail to return to the police station or to attend court, the police must notify victims of this, along with the reasons for granting bail and any relevant bail conditions, within five working days. Similarly, if bail conditions are altered or bail is cancelled, the police must notify victims within five working days.

14. **Treatment of NHS staff as victims**

14.1. The CPS is committed to delivering the *CPS Public Policy Statement on the Delivery of Service to Victims* to all witnesses. This is reflective of the Farquharson Guidelines on the Roles and Responsibilities of Prosecution Advocate and the Bar CPS Standard for Communication between Victim and Witnesses and the Prosecution Advocate.

**Decision to prosecute**

14.2. It is the duty of the CPS to ensure that victims are informed of charging decisions taken by the CPS. In a case in which a person has been charged but a decision is then made by the CPS to discontinue, or the initial charge is withdrawn and a less serious charge is preferred, the prosecutor will write to the victim to inform him or her of the decision and the basis upon which it was made.

14.3. If an initial decision is taken not to charge after discussion with the investigating officer, it is the responsibility of the police to notify the victim. If a decision is taken not to charge after a prosecutor has received a full evidential file other than during discussion with a police officer, it will be the responsibility of the CPS to notify the victim of the fact. In any circumstance, this may be done through the NHS health body Lead Director. If, in accordance with CPS guidance, it is decided that the victim should not be told, the NHS health body Lead Director should be informed of this fact.

14.4. Welsh Health Legal Services should also be informed of decisions not to prosecute via the police and NHS health body Lead Director.
14.5. If, after an offender has been charged, the CPS takes a decision to alter substantially or drop any charge, the CPS will notify the victim. In certain serious cases, the CPS must offer to meet the victim to explain a prosecution decision.

14.6. When a plea of guilty is offered to the CPS at court, and wherever practical, the prosecutor will speak with the victim or victim’s family attending court to ensure that any views expressed are taken into account when considering the acceptability of the plea. If necessary, the prosecutor will seek an adjournment in order to facilitate a discussion.

**Witness Care Units**

14.7. Joint police and CPS Witness Care Units (WCUs) are responsible for supporting victims and witnesses and keeping them informed about progress of their case, following a ‘not guilty’ plea by a suspect. The WCU will:

- provide a single point of contact for a victim or witness in a case
- conduct a full needs assessment with all victims and witnesses where a ‘not guilty’ plea is entered
- notify victims and witnesses of any requirement for them to give live evidence, and any subsequent amendment to this requirement
- notify victims and witnesses of the date of all criminal court hearings, and any subsequent amendments to that date
- provide victims and witnesses who are to be called as witnesses with a copy of the ‘Witness in Court’ leaflet
- notify victims and witnesses of the outcome of all pre-trial hearings, the verdicts of the trial, the sentence if the suspect is convicted and the effect of that sentence.

**Victim care during progress of a case**

14.8. The prosecutor will always address the specific needs of a victim or witness.

14.9. Before every trial, prosecutors will consider whether it is absolutely necessary to require the attendance of a witness. Where possible, the CPS will seek to agree evidence, although it is a matter for the defence whether they wish to agree any evidence or not. Ultimately, the success of a prosecution must not be jeopardized by the prosecutor dispensing with a witness’s attendance for reasons of convenience.
14.10. The service of copied originals of the medical notes, which can be attached to the relevant statement, may help in the avoidance of calling a member of NHS staff as a witness.

14.11. When NHS staff are required to attend court to give evidence and support a prosecution, the CPS will seek to minimize the impact of them being called through standby arrangements. Where the distance from the hospital or place of employment to the court makes it a practical option, such arrangements will be offered.

14.12. The CPS will consult the court to see if agreement to the terms of the standby arrangements can be obtained and will inform the police of the agreed arrangements. Full use should be made of pager/bleep numbers and mobile telephones.

Special Measures

14.13. Where a victim who is to be called as a witness in criminal proceedings has been identified as potentially vulnerable or intimidated as defined in sections 16 and 17 of the Youth Justice and Criminal Evidence Act 1999, Special Measures may be applied for to assist them in giving their evidence at court. These Special Measures may include giving evidence behind a screen or via a TV link so that the witness does not have to give evidence in court. The availability of Special Measures will depend on whether the witness if vulnerable or intimidated.

14.14. It is the role of investigators to establish at an early stage whether a witness is likely to qualify for a ‘Special Measures Direction’ and, if so, which particular measures will assist. The views of the victim will be important as to whether and which Special Measures should be applied for, and will be carefully considered. The CPS will specifically consider applying for Special Measures in such circumstances.

14.15. The WCU will ensure that any change of circumstances that may affect the victim’s decision on Special Measures is appropriately communicated to that person and, likewise, communicate back to the police and CPS any change of views/circumstances that the witness may have experienced.

Compensation

14.16. When the victim has been injured or has suffered financially, or the relevant NHS body has suffered financial loss or damage, the CPS will:

- ensure that the information given to prosecutors on compensation claims is sufficient for the court to make compensation order, if it wishes
- remind the court of its power to award compensation in cases where there is no financial loss (e.g. personal injuries sustained)

- remind the court that it must give reasons where a compensation order is not made if the case is one in which an order may have been possible.

**Sentencing**

14.17. When relevant, the police should obtain a Victim Personal Statement and check its accuracy with the NHS health body Lead Director. This statement can then be relied upon by the prosecutor when an offender is being sentenced and will provide the court with a full and up-to-date picture of the impact of the offence upon the victim.

15. **Communication and liaison**

15.1. The NHS health body Lead Director and CPS should develop local protocols in order to develop and improve communications at local level. This can be facilitated by the nomination of a CPS Liaison Officer who will link in with the NHS health body Lead Director.

15.2. The key objectives in building a local communications network between the NHS, CPS and police are:

- to improve the protection of NHS staff
- to strengthen the prosecution process, by improving the quality of information exchanged
- to improve victim and witness care.

15.3. Police designated divisional/area single points of contact, as outlined in the Memorandum of Understanding between the Welsh Assembly Government and ACPO (Wales), should also be consulted to provide a consistent approach and ensure that a national standard approach is taken. A list of NHS health body Lead Director for specific CPS areas can also be obtained by emailing Christopher.John.Beadle@Wales.gsi.gov.uk detailing the area or NHS trust required.

16. **Disclosure of Information to Welsh Health Legal Services**

16.1. Whilst Welsh Health Legal Services will work with health bodies and provide them with advice on cost-effective methods of pursuing sanctions against offenders and will work with the police and the CPS in order to increase the rate of prosecutions arising from physical and non-physical assaults, there may also be occasions when the victim or their health body requests Welsh Health Legal Services to review a
case to determine whether private criminal or civil action is appropriate and the CPS will supply the evidential case file expeditiously with the usual safe guards. This may arise following a decision by the police and/or the CPS not to charge an offender or not to proceed with a criminal prosecution.

16.2. Welsh Health Legal Services may require a copy of the evidential case file in order to make an informed judgement on whether criminal or civil proceedings are appropriate. If criminal proceedings are anticipated, Welsh Health Legal Services will apply its internal prosecution policy and adhere to section 5 of the CPS Code for Crown Prosecutors.

16.3. Such requests should be directed to the police. If the CPS receives such a request, it will be forwarded to the police for consideration. It is a matter for the police or Witness Care Units to obtain the consent of witnesses or other individuals before personal information relating to them is released to a third party. This is in line with the obligations placed upon the CPS and police authorities contained within the Data Protection Act 1998. Due regard must, however, be given to any relevant information-sharing gateways - in particular, sections 29 and 35 Data Protection Act 1998, for the release of information in appropriate circumstances.

16.4. Where Welsh Health Legal Services is considering a private prosecution, the prosecutor should, when requested, consider providing a full explanation of their decision not to prosecute or why the offender was cautioned.

17. Disclosure of information to the Police and CPS from the NHS Trusts

17.1. The Welsh Assembly Government recognises that NHS Trusts in Wales will often hold essential information for the purposes of court proceedings. Very often the Police and Crown Prosecution Service will require access to patients notes, either in order for the prosecution to prove the case against the defendant, or for the court to determine the level of compensation payable to the victim. The Police and Crown Prosecution Service recognise that the access to patients notes and other personal information under Section 35 of the Data Protection Act will cause administrative problems for NHS Trusts in the absence of an agreed procedure for obtaining such information.

17.2. In order to overcome this problem the Police and Crown Prosecution Service have developed a procedure between themselves and certain Trusts in Wales. The procedure envisages that the Police will make applications for medical statements and medical records pursuant to Section 35 of the Data Protection Act. The NHS Trusts have agreed to release such documentation within 28 days. There is an agreed form of application and an agreed fee. The CPS and
Police recognises the pressures on the Trusts to meet all requests within the timescales and will themselves act promptly at all stages to assist.

17.3. The Welsh Assembly Government commends such agreements between the Police, Crown Prosecution Service and NHS Trusts in Wales. The Welsh Assembly Government will recommend to those Trusts that have not yet entered into such agreements that they should do so within a reasonable time. The point of contact for NHS Trusts on this matter within the Welsh Assembly Government is Christopher Beadle at the email address given at 15.3
The Welsh Partnership Forum Staff Survey Survey of 2007 provided some very interesting information against which other existing data and perceptions of violence and aggression themes could be triangulated.

Significantly, the 2007 Staff Survey saw a significant reduction in response rate from the previous (2005) Survey and against other benchmark figures. The 2007 survey response rate was 31% (26963) compared to the UK average of 62%. Overall responses across NHS-Wales Trusts was 29% whereas Local Health Boards fared better at 52%.

Accidents at Work section of the survey show that 7% of respondents have received an accident at work in the last year and 23% of respondents have reported personal experience of a violent or aggressive incident at work. Of the respondents only 67% of them claim to have reported the incidents and of these, a little over half (57%) were satisfied with the outcome.

This data demonstrates not only poor reporting of incidents as 1/3 of the respondents have failed to report at all. It also shows that NHS-Wales staff are dissatisfied with the outcomes which reinforces the views from staff interviewed that matters were not fully investigated and that their (perceived) appropriate actions were not taken.

A serious matter as regardless of outcomes, it is important that reportees are communicated with and outcomes explained and discussed.

The vast majority of reported incidents show that patients/service users were the cause of the incident and that relatives of patients and members of the public were the second major group. This information corresponds with figures available from all-Wales reported incidents.

Reporting of incidents was a specific theme of the Staff Survey. 52% of respondents reported that their reason for not reporting was a belief that nothing would happen. Other significant reasons given were related to the time involved reporting (17%), concerns about confidentiality (14%), fear of the consequences of reporting (11%), length of time to action (15%). Each of these reasons correspond with accounts given by staff who were interviewed as well as the reported incidents data. Reinforcing the suspicions that under-reporting is a significant problem and indicating some of the perceived reasons why.
APPENDIX E
REPORTED INCIDENTS (2003-2006)

The available data of reported incidents NHS-Wales for the 3 year period 2003-2006 was considered. The data was in part incomplete and it was difficult to build up a real picture of violence and aggression across NHS-Wales from this alone.

The data however was useful in demonstrating some trends in NHS-Wales and particularly that reported violence and aggression incidents is increasing. (It is good news that staff are reporting but still believed to be significant under-reporting despite the trend upwards).

The number of physical violence incidents from patients to staff in NHS-Wales has risen from 2376 in 2003 to 3281 in 2006. This represents only reported incidents and the data is not sufficiently accurate or detailed to allow at an all-Wales level any form of further exploration of data; it is not possible to ascertain from these numbers what the nature of the violent/aggressive act was and if it was due to some pre-existing ‘therapeutic’ condition (eg; dementia) or whether it was a direct unprovoked assault.

Physical violence from visitors is reported as being much lower (706 in 2003) however, the figure has more than doubled in two years and is reported at 1430 in 2006.

The reported incident data was interesting in that it showed consistent and similar reported numbers across most specialties with mental health and learning disabilities staying in high reporting levels year on year.

Areas showing declines in reported incidents over the period include surgery, obstetrics and gynae, medicine and community.

Most interestingly however, anticipated areas of higher risk were felt to be front-line services including accident/emergency and ambulance staff. However, both of these areas are amongst the lowest reported areas of practice having any reported incidents of violence and aggression with moderate numbers (between 328-381 for A/E and 236-254 for Ambulance). Community settings, Medicine, Surgery, EMI, Mental Health and Learning Difficulties have all reported significantly higher incidents during the same 3 year period.
For this reason discussions with a number of local Safety Officer/Leads across Wales as well as NHS-Wales Staff and staff victims. It is clear from all of these discussions that under-reporting is a significant phenomenon and that in certain areas (A/E and Ambulance) it is particularly prevalent. It appears that very little verbal incidents are ever reported in these (not exclusive) areas and it is almost seen as a cultural norm to be exposed to (and accept) verbal aggression.

It is also possible to identify geographical boundaries of cultural ‘acceptability’ with areas (eg; objective 1) presenting some behaviours as acceptable norms which would be wholly unacceptable in other departments in NHS-Wales.

The limited data from reported incidents and responses from interviewees does strongly support the premise that under-reporting is significant and common. It also clearly shows that violence and aggression towards NHS-Wales staff is increasing.
Appendix F
Lone Worker-Business Case

<table>
<thead>
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<tr>
<td>REPORT AUTHOR(S)</td>
<td>Chris Beadle</td>
</tr>
<tr>
<td>DATE WRITTEN</td>
<td>15th January 2008</td>
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**TITLE OF REPORT**
A business case for the provision of a Lone Worker alert system for NHS Trusts in Wales.

**PURPOSE OF REPORT**
The purpose of this business case is to seek approval from the Minister for Health and Social Services to purchase an automated Lone Worker alert system for NHS Wales.

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**Introduction**
Under the Health and Safety at Work Act 1974, the NHS in Wales has a duty to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all employees and any other persons liable to be affected by its work activities and undertakings. The main purpose of this business case is to improve the safety of all Lone Workers in the NHS Trusts in Wales.

The definition of a Lone Worker would be best described as someone who works alone or in a vulnerable position, without direct or close supervision generally being remote from others but not always. This could in fact cover any member of staff working in the NHS. For example, it could be a senior manager attending a meeting on their own off site, it could be a community nurse visiting a patient at home, it could be a carpenter repairing a window in the early hours of the morning following a break in to a community premises or it could be a podiatrist working alone in a health centre.
In 2002/03, it was estimated that there were 116,000 incidents of violence against NHS staff ranging from verbal abuse to serious physical assaults. Although it is not known what proportion related to attacks on Lone Workers, it is widely recognised that this group of staff face significantly increased risks as they do not benefit from the immediate support of colleagues or others - such as security staff, should an incident occur. For example, they may not be able to easily withdraw from a situation, particularly if they are in a patient home. Alternatively, they may be working in high crime area or an isolated rural location, or they may be working at night in an isolated location. Additionally, they may be in possession of equipment or drugs that might be attractive to others who may want to steal these and, in some cases use violence to achieve this.

The dangers and problems that Lone Workers may face have been graphically illustrated by some high profile incidents throughout the public and private sector. The most well known is that of the Estate Agent, Suzy Lamplugh, who went missing following a pre-determined meeting to show a prospective client around a property. Her disappearance raised the profile of Lone Workers and the risks that they face, as well as leading to the creation of a charity, bearing her name, which has become an invaluable source of guidance and advice on training and support mechanisms to help better protect this group of staff.

Trade Unions believe that any of their members working alone should not be at greater risk in their jobs than other workers and would therefore expect employers to risk assess all lone working activities and put reasonable measures in place to address them.

On 2 March 2005 the NHS Security Management Service (SMS) launched national guidance on lone worker policies. This has been designed in conjunction with NHS health bodies and key stakeholders such as the Suzy Lamplugh Trust. The guidance can be used to develop or revise procedures locally in health bodies so that these meet the diverse needs of their staff and the environments that they work in. This guidance is not unlike the information NHS Wales have included in the All Wales Violence and Aggression Training Passport and Information Scheme.

An announcement was also made on 25th September 2007 by the Department of Health about the availability of £29 million to be spent on 30,000 safety alarm devices for lone workers. As well as including an alarm function, the device will help locate the user and link to a trained individual who can summon help if needed. The system proposed in Wales is similar to that in England.
It is recommended that all Trusts across Wales meet a common standard in the provision of a Lone Worker monitoring system capable of automatically generating remote alarms under certain conditions. Therefore the following business case has been developed to this aim. It should also be noted at this stage that if the Welsh Assembly Government approves this procurement, it could also be considered for use in all local authorities across Wales, as they often share the same client group and they too should also be addressing the same risks associated with working alone.

**Strategic Content**

In line with developments to ensure best practice across NHS Wales, several ‘Passport’ Schemes have been developed over the past few years. This proposed business case, which is linked to the Violence and Aggression Passport Scheme, is to assist management and staff to ensure that practice and learning can be transferable if staff relocate from one Trust to another.

Currently in Wales all Trusts will have appropriate Lone Worker Policies in line with the recommendations of the All Wales Violence and Aggression Training Passport and Information Scheme. These policies detail steps that should be in place to minimize the risks to lone workers, for example, ‘buddy’ systems, use of switchboards to record staff whereabouts, the issuing of panic alarms to staff, etc. There are however five Trusts that have in place lone worker alert systems (Powys, Ambulance, North West Wales, Pontypidd & Rhondda and Cardiff and Vale). Of these five Trusts, three of them have purchased the same system and the Ambulance Trust manages their own system through their communications system. The remaining Trusts in Wales are awaiting the decision of this business case to decide whether or not to progress with the procurement of a system for their individual needs.

To ensure there is a demand for a lone worker alert system in Wales, each of the Trusts with a system in place were contacted for information on incidents where the system had escalated. None of the Trusts had experienced an incident where the system had been used to full effect since installation. It should be noted that of the five Trusts, only one system had been fully implemented for over 12 months. As a result of this, the remaining Trusts in Wales were contacted to provide information on incidents where a lone worker alert system would have been advantageous. Some examples of these incidents are attached as Appendix 1.
The advantages of a centrally procured system include procurement savings through economies of scale, and uniform practice across all Trusts when addressing the risks to lone workers.

**Aims/Objectives of the Proposal**
Listed below are the main objectives of the proposal and system:

- To provide a safe system of work to ensure, so far as is reasonably practicable, the safety of all lone workers in the NHS in Wales
- To have in place a common alert system for all staff in NHS Wales who work alone.
- All staff required to work alone have access to a mobile communication/phone.
- All lone workers are provided with common training for use of the alert system.

**Service Description**

**Requirements for Roll-Out from the Welsh Assembly Government**
The main requirements for the Welsh Assembly Government are as follows. Firstly there is a requirement that there is agreement in principle from the Welsh Assembly Government to procure an alert system for lone workers. Secondly, the Welsh Assembly Government would be required to nominate an individual to work with the All Wales Lone Workers Sub Group to clarify the brief, and prepare tender documentation and then the implementation of a system. Finally, the Welsh Assembly Government would need to explore further development and expansion of the system, for example to local authorities.

**Requirements for Roll-Out from a Trust’s Perspective**
Once the system purchase is approved, there will be a requirement for it to be implemented in each NHS Trust across Wales. The implementation will not only require technical expertise, but also agreement on issues such as Escalation Procedures and appropriate responses.

It would be essential that a lead individual will be allocated in each Trust, whom will be responsible for the implementation of both the technical and practical solutions for the system. This individual will be of a senior enough level in the Trust to be able to take appropriate actions.
The individual will also be required to work with the All Wales Lone Workers Group to ensure that a consistent approach and training is provided across Wales to the implementation of the system.

- Assemble Information Database

  If not already available each Trust will have to assemble a comprehensive database of staff. This must include sufficient personal details to locate that person by description, together with their car details etc.

- Gather Additional Information

  Each Trust should then issue a form for all staff to complete that provides telephone numbers of contacts and others that may know their whereabouts should they fail to inform base that they are safe at the end of a shift or call. The first most obvious may be their Team Leader, as they would normally have a work rota available. The second may be a close relative. These details will be held at the base and will be used in the event of the Alert system instigating the alert procedure.

- Send Lone Worker Information to Control and retain a copy

  Lone Worker names, base, surgery, designation and mobile telephone numbers and photograph if available, are to be sent to a control for the attention of the lead individual for the implementation of the alert system. This information will then be entered onto the Lone Worker computer system. Then a return list may be issued detailing Lone Worker numbers for each individual member of staff.

- Determine Group Telephone Numbers

  Each Trust should then decide which base telephone numbers are to be used in an emergency and forward these to the lead individual for the implementation of the alert system. For example during the day and in office hours, the system will in an alert situation, ring this chosen number and if engaged it should go to a second predetermined number if possible. In any event the chosen number will continue to ring until answered. Evenings, weekends and out of hours alerts may be dealt with at hospital main switchboard or on call managers.
• Agree Trust Escalation Procedure

Each Trust will have to write a Trust Escalation Procedure that would come into effect should an alert situation occur and keep this with the base folder that contains the staff details. It will vary from Trust to Trust or even hospital to hospital, but the general body content would remain the same. The escalation procedure will also cover incidents out of normal hours and at weekends.

• Audit Trail from the Base/Group prospective

It is most important to have an audit trail to enable base staff to record any events as and when they happen. These would include, who phoned, what time, what did they say and if necessary informing the police as the final outcome etc. This will enable the Trust to identify training problems, repeat offenders and of course and most importantly be in a position to locate the member of staff.

• Training

Each Trust must ensure that staff operating or as part of the response team for the lone worker alert system would have appropriate training in the safe operation and use of the system. It is intended that the All Wales Lone Worker Group can specify the contents and level of training required, to keep in line with ‘passport’ requirements.
**Capital and Revenue Resources**

These are a list of both the capital and revenue resources required for the implementation of a lone workers alert system:

1. **Purchase of an alert system for each Trust in Wales based on the following figures:**

   **Total Number of Lone Workers Across NHS Wales**
   (Including number of mobile phones allocated where available)

<table>
<thead>
<tr>
<th>Trust</th>
<th>Approximate Number of Staff employed</th>
<th>Number of Lone Workers</th>
<th>Number of Mobile Phones</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bro Morgannwg NHS Trust</td>
<td>6000</td>
<td>833</td>
<td>395</td>
</tr>
<tr>
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<td>11500</td>
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<td>1000</td>
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<td>180</td>
<td>(Not Known)</td>
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<td>Conwy and Denbighshire NHS Trust</td>
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</tr>
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<td>Gwent Healthcare NHS Trust</td>
<td>12000</td>
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<td>1500</td>
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<tr>
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<td>4800</td>
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<td>North West Wales NHS Trust</td>
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<td><strong>4564</strong> (Not Full Picture)</td>
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The figures in Bold have been actually provided by the Trusts. Those in normal text have been calculated based on approximately 15% of all staff being lone workers.

A Lone Worker Alert system can be provided either through the ‘lease/purchase of Trust based hardware’, or through subscription to a ‘managed service’ where the hardware is located and managed off-site.
Estimated costs for both systems are detailed below.

- **System 1** – Trust Managed System
  With this system, the Trust would be required to install hardware into the organisation and both set up the system and manage it on a day to day basis. Initial estimated costs provided to date are as follows:
  - 11 systems for Trusts = £250,000 or £21 per user per year (includes Hardware/Software/ Microsoft Licenses/Installation /Training and 1st years maintenance)
  - If leased over 5 years = £5636 per month or £0.69 per user per month
  - If leased over 7 years = £4768 per month or £0.58 per user per month

- **System 2** – Externally Managed System
  With this system there is no hardware required for Trusts. An account is set up with the company and each organisation is then allocated its number of users. Based on the figures above, this system is estimated to cost £36 per user per annum, the cost for NHS Wales is £440,000. The other initial cost that would have to be allocated would be in relation to training. This system would require Trusts to have a group of individuals trained as trainers. Each trust would therefore require one training session at £125 per session resulting in an additional charge of £1750. On top of these costs would be those included below.

**2 Maintenance Costs**
With system 1 there will be a requirement to pay an annual maintenance cost for the systems. This is estimated at approximately £22,000 per annum. As for system 2, there are no maintenance costs as there is an annual user cost (currently £36 per user per year) for as long as the contract is awarded.

**3 Extra Mobile Phones**
All Trusts by now will have issued their lone workers with mobile phones. As Trusts look further into the issues of lone working and the introduction of an alert system, it is anticipated that there will be a requirement for additional mobile phones to support this system. From one Trust’s experience of introducing this system their mobile phone demand increase from 617 to 751 an increase of 18%. It is anticipated that these costs will be met by individual Trusts.
**Extra Phone Call Costs**
To alert or deactivate alerts on either system 1 or 2, there may be a requirement to make additional phone calls to current practice. It is possible for the system to be set up on a free phone number, which may become more cost effective in the long run depending on usage. It is anticipated that these costs will be met by individual Trusts.

**Switchboard Hardware and Configuration Costs**
Dependant on the technology within each Trust, there may be additional requirements for switchboards to be upgraded to accommodate System 1. Trusts would also benefit from the use of the Lone Worker system in the digital form as the load handling and reduction in the telephone lines would be more cost effective. Software updates, modifications and maintenance would also prove to be the preferred route. One Trust has estimated that to upgrade from Analogue to Digital would cost approximately £2,000 to £5,000. It is anticipated that these costs will be met by individual Trusts.

**On-Call Arrangements**
To ensure that each Trust has an escalation procedure to an alert of the system 24 hours a day, 7 days a week, there may be a need for each Trust to review their current on-call arrangements. If there is a requirement for more staff to be on-call out of normal hours, there may be additional staff payments required. It is anticipated that these costs will be met by individual Trusts.

**Staff Training Costs**
Once either system is purchased and installed, there will be a requirement for all users of the system to receive training and instruction in its use. It is anticipated that training will take no longer than 3 hours for each new user. Trusts will therefore have to release all staff affected to receive this training. It is anticipated that these costs will be met by individual Trusts.

There are also costs incurred for either variant of system relating to the ongoing administration of the user database(s). We anticipate that each department utilising the system, will be responsible for the maintenance of their ‘Lone Worker’ data.
Benefits of the Proposal / Consequences of not Proceeding

There are many benefits to providing this system to all lone workers in the NHS in Wales. Detailed below is a selection of these:

- **Statutory and Legal Requirements**
  If this system is provided, each Trust will be clearly able to demonstrate that it has made sufficient improvements in its duty of care to ensure so far as reasonably practicable, the health safety and welfare of all lone workers. This would then demonstrate compliance with health and safety legislation and enable support from Trade Unions.

- **Improvements in Staff Welfare**
  Stress to staff is a risk in all activities undertaken in the workplace. It has been identified that those staff who have little control over their working conditions and have little contact with their colleagues or managers are more at risk from suffering with stress related illnesses. Lone workers could therefore fit into these categories. If an alert system were to be implemented across Wales, it could be expected that staff confidence will be increased as there would be a feeling that their employer cares about their health and safety. This may then have an impact on staff retention and also improve the moral of the existing staff. In turn it would be hoped that there would be lower levels of sickness.

- **Improvements in Patient Care**
  With improvements in communication for lone workers, each Trust could be expected to see increased levels in efficiency due to lower levels of sickness as described above as well as concise planning of lone worker activities. If there is less sickness, patients would benefit from continuity of care by designated staff always attending to them in the community.

- **Transferable skills**
  The expected benefits for an all Wales lone worker alert system is that if staff who work alone transfer their employment between Trusts, the same level of protection can be provided and in a common format. Any training on the alert system provided can also be transferable between Trusts.
• **Other Benefits**
  Other benefits would include cheaper purchase/maintenance of an alert system if purchased centrally and shared experience for installation by all Trusts. If the Welsh Assembly Government were to purchase an all Wales alert system, the NHS could expect a bigger mandate to get suppliers to make system changes if required, for example links between Trusts to provide a Standardised Database for sharing offenders’ information. Some systems can also add non related additional benefits, for example automated major incidents, voice mail and auto attendant, etc.

**Arrangements for the Evaluation of the Scheme**

It is anticipated that this scheme will be evaluated in the following ways:

• **Compliance with Legislation**
  To measure compliance with legislation, each Trust must review their current risk assessments for lone working. It would be expected that with the introduction of an alert system, the level of risk would be reduced to reasonable levels. This would provide assurances to the Health and Safety Executive that each Trust was in compliance with the Health and Safety at Work Act and Management of Health and Safety at Work Regulations.

• **Audit**
  Following the implementation of the alert system, it would be expected that each Trust undertake regular audits to measure the success of the implementation and usage of the system.

• **Staff Questionnaires/Surveys**
  After the first year following the introduction of an alert system, each Trust will be expected to undertake a staff questionnaire with a random selection of lone workers to determine how much safer lone workers feel having the system.
Option Appraisal
The preferred option would be the purchase of system 1, a Trust Managed System. In relation to the funding source for how this purchase could be made, there are four options to consider:

1. Welsh Assembly Government centrally funds the procurement of a lone worker alert system for all NHS Trusts in Wales. The positive aspect of this would be that the Welsh Assembly Government will have assurances that all Trusts have in place adequate measures to manage the risks to lone workers. The downside to this could be that there is no money centrally to fund this option or that Trusts would not have total ownership of the project as it is not them that are funding it. All other costs pertaining to the implementation of the system will be met by each Trust.

2. Welsh Assembly Government centrally funds a percentage and each Trust is top sliced (pro rata) for the remainder, for the procurement of a lone worker alert system for all NHS Trusts in Wales. The positive aspects of this would again be that the Welsh Assembly Government will have assurances that all Trusts have in place adequate measures to manage the risks to lone workers. As Trusts would be part funding it, there is also more likelihood that there would be better ownership by the Trusts to the implementation of the system. The downside to this could be that there is no money available in the Welsh Assembly Government or Trusts to fund this option. All other costs pertaining to the implementation of the system will be met by each Trust.

Recommendations
To ensure that the NHS in Wales is meeting both best practice and legal requirements for the management of risks to lone workers, it is recommended that the Welsh Assembly Government agree to this business case and tender for the procurement of an alert system using one of the options outlined above.

Attached to this document, as Appendix 2, is an output-based specification for an alert system that has been developed by the All Wales Lone Workers Sub Group.
Bibliography

The All Wales Violence and Aggression Passport Scheme

The Health and Safety at Work Act 1974

The Management of Health and Safety at Work Regulations 1999

Workplace (Health, Safety and Welfare) Regulations 1992

Working alone in safety (INDG73) revised 1998 – Health and Safety Executive.

Homeworking – guidance for employers and employees on health and safety (INDG226) - Health and Safety Executive.


Violence and Aggression to staff in the Health Services - Health and Safety Executive.

Managing Occupational Road Risk – The ROSPA guide

Stress at work. Guidance for safety representatives UNISON Publications
MINUTES OF THE FIRST MEETING OF THE TASKFORCE TO DEAL WITH VIOLENCE AND AGGRESSION IN NHS WALES

10.00AM, WEDNESDAY 12 DECEMBER 2007, SEMINAR ROOM A, ROYAL COLLEGE OF NURSING HEADQUARTERS, TY MEATH, CARDIFF

Present

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
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<tbody>
<tr>
<td>Dave Galligan (Chair)</td>
<td>UNISON</td>
</tr>
<tr>
<td>Jayne Carroll</td>
<td>District Nurse Team Leader, Gwent Healthcare NHS Trust</td>
</tr>
<tr>
<td>Adrian Williams</td>
<td>Clinical Nurse Specialist, North West Wales NHS Trust</td>
</tr>
<tr>
<td>Gwyneth Pritchard</td>
<td>Chair, NHS Wales Violence and Aggression Steering Group</td>
</tr>
<tr>
<td>Terry Rose</td>
<td>Director, Wales Health and Safety Executive</td>
</tr>
<tr>
<td>Clare Owen</td>
<td>HM Inspector, Health and Safety Executive Wales</td>
</tr>
<tr>
<td>Tim Harrison</td>
<td>Chair, NHS Wales Health and Safety Advisers Forum</td>
</tr>
<tr>
<td>Gaynor Jones</td>
<td>RCN Local Steward, North Glamorgan NHS Trust</td>
</tr>
<tr>
<td>Erica Stamp</td>
<td>Assistant Secretary, BMA Wales</td>
</tr>
<tr>
<td>Russell Hoare</td>
<td>Security Manager, North Glamorgan NHS Trust</td>
</tr>
<tr>
<td>Martin Nevard</td>
<td>UNITE, Swansea NHS Trust</td>
</tr>
<tr>
<td>Chris Beadle</td>
<td>Occupational Health and Safety Policy Lead, NHS Wales, Welsh Assembly Government</td>
</tr>
<tr>
<td>David Wallace</td>
<td>Violence and Aggression Taskforce Coordinator, Welsh Assembly Government</td>
</tr>
<tr>
<td>Ralph Batten (Secretariat)</td>
<td>Welsh Assembly Government</td>
</tr>
</tbody>
</table>

1. Election of Chair

Dave Galligan was elected Chair.
2. Apologies and Introductions

Taskforce Members introduced themselves. Apologies were received from Peter Finch, Assistant Director of Employment Relations and Union Services, CSP Wales, Tania Marsden, HR Director, North West Wales NHS Trust and Richard Jones, Deputy Director, RCN Wales.

3. Background

Chris Beadle reported that the Minister for Health and Social Services had recently visited NHS Trusts, Large Hospitals and Community Hospital across Wales. As a result of these visits, the issue of Violence and Aggression towards staff working in NHS Wales had been identified as one of the top ten priorities to address and, to this end, the Minister had met with Tina Donnelly at the RCN Wales to discuss the secondment of a member of her staff, Mr David Wallace, to administer the work of a task force she intended to set up to look into issues surrounding the protection of staff.

The three main areas that the Task Force would address would be incident reporting, prosecutions and support for victims.

The Task Force would provide its initial report to the Health Minister by Easter 2008 and its final report by June or July 2008.

David Wallace then explained that he had been seconded to the Welsh Assembly Government for a short period to manage the work of the Task Force.

Based on information and figures provided by Trusts, he had identified that areas surrounding training and under-reporting of violent incidents needed to be addressed. He would provide information on the data he had collected to all Taskforce Members.

Taskforce Members then confirmed that they were comfortable with the explanation of the background.

<table>
<thead>
<tr>
<th>Action Point</th>
<th>To provide Taskforce members with information on the Violence and Aggression Data he had collected</th>
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4. Agree Terms of Reference

The Chair drew the attention of the Taskforce to the Terms of Reference Document.

The following membership issues were raised:

- Chief Executive Nominee - Ralph Batten had written to Hugh Ross, Chief Executive, Cardiff and Vale NHS Trust, inviting him to become a member of the Taskforce. It was noted that Mr Ross was not present. Mr Batten would contact Mr Ross again.
- Welsh Ambulance Service Nominee – Chris Beadle reported that Martin Nevard, the UNITE representative, had an ambulance service background.
- Welsh Partnership Forum Nominees – The Chair reported that the Health Minister had not taken nominations directly from the WPF. However, the Taskforce was not prevented from co-opting new members as and when
necessary. Chris Beadle agreed saying that the relevant expertise would be brought into the Taskforce as and when necessary.

David Wallace suggested including an extra item in para 3.1 on Lone Working. Terry Rose suggested adding details of the work timetable into the Terms of Reference.

<table>
<thead>
<tr>
<th>Action Point 1</th>
<th>To contact Hugh Ross regarding the nomination of a Chief Executive to serve as member of the Taskforce</th>
<th>Ralph Batten</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action Point 2</td>
<td>To amend the Terms of Reference to reflect what has been agreed in item 4</td>
<td>Ralph Batten</td>
</tr>
</tbody>
</table>

5. Discussion on Work Programme

A discussion took place around the potential components of a work programme and the following issues were raised.

Incident Reporting – Gwyneth Pritchard reported that the NHS Wales Violence and Aggression Steering Group were developing a standardised incident coding system to facilitate the recording of violent incidents. She was happy to share information on the work of the group with the Taskforce. It was suggested that the Taskforce could develop a standardised incident recording form. The Taskforce could also develop guidance as to when incidents should and should not be reported. It was reported that guidance on this could already be found in the All Wales Violence and Aggression Training Passport and Information Scheme.

Prosecution – It was noted that staff were reluctant to take out prosecutions because of the reluctance of Trusts to support them in this process. Chris Beadle thought that the recently developed Memorandum of Understanding (MoU) with the Crown Prosecution Service (CPS) would help in this area. Also, he was working to develop a similar MoU with the four Welsh Police Forces. The Chair recommended that the Taskforce needed to find out if they could engage with the Welsh Police, the CPS and the Welsh Health Legal Service and it would be interesting to have a cross-border view on any prosecution difficulties. Chris Beadle reported that there would be no problem in seeking the input of the Counter Fraud Security Management Service in England and there also needed to be interaction with Trade Unions at a local level.

Information Sharing – Chris Beadle reported that the Counter Fraud Security Management Service were looking to develop an internet-based information sharing system which would share information on violent individuals on a either a local or national basis. Terry Rose recommended that the Taskforce should develop an Information Sharing Alert System similar to the one used in Welsh Schools. Chris Beadle warned that individuals could not be placed on a database if they had not been convicted of any crime. There were Data Protection and Human Rights issues to
consider. The Chair recommended that the Taskforce needed to develop best practice regarding information sharing. Chris Beadle suggested enlisting the help of colleagues in other UK countries as well as the Police. He recommended that the Police should have representation on the Taskforce to help in this area. It was agreed that Chris Beadle and David Wallace would undertake research in this area and report back to the next meeting. Also, Taskforce members agreed e-mail Ralph Batten details of any Information Sharing systems that they were aware of.

Lone Working- It was agreed that the Business Case for the provision of a Lone Worker alert system for NHS Wales submitted to the WPF Healthy Workforce Sub – group in 2005 would be used as starting point for the development of a Lone Worker Alert system. Chris Beadle agreed to circulate a copy of the Business Case to all Taskforce members.

Staff Support – The existence of NICE guidelines in this area was confirmed. It was agreed that Chris Beadle and David Wallace would undertake a mapping exercise, by means of a questionnaire, to ascertain the current level of staff support offered by NHS Trusts in Wales. Russell Hoare reported that the Victim Support Service had done a lot of work in this area. Adrian Williams raised the issue of access to independent counselling services. He was happy to circulate the Department of Health Guidelines for the counselling of staff who had experienced traumatic incidents.

The Physical Environment – Chris Beadle raised the issue of how to prevent gangs of potentially violent individuals turning up at A & E premises at any one time. Russell Hoare commented that changes in building design could help in this area and he was happy to share information on this in time for the next meeting.

<table>
<thead>
<tr>
<th>Action Point 1</th>
<th>To share information on the work of the NHS Wales Violence and Aggression Steering Group in the area of Incident Reporting with the Taskforce</th>
<th>Gwyneth Pritchard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action Point 2</td>
<td>To undertake research in the area of Information Sharing and report back to the next meeting</td>
<td>Chris Beadle / David Wallace</td>
</tr>
<tr>
<td>Action Point 3</td>
<td>To e-mail Ralph Batten details of any Information Sharing systems that they are familiar with</td>
<td>All Taskforce Members</td>
</tr>
<tr>
<td>Action Point 4</td>
<td>To e-mail details of any Information Sharing Systems received to all Taskforce Members</td>
<td>Ralph Batten</td>
</tr>
<tr>
<td>Action Point 5</td>
<td>To circulate a copy of the Lone Worker Alert System Business Case to all Taskforce Members</td>
<td>Chris Beadle</td>
</tr>
<tr>
<td>Action Point 6</td>
<td>To circulate the DoH</td>
<td>Adrian Williams</td>
</tr>
</tbody>
</table>
6. Resource Issues for Items Discussed in Agenda Item 5

The Chair advised that there would be financial consequences for any anti-violence initiatives developed by the Taskforce.

Chris Beadle advised that the Minister would be happy to provide funding for any reasonable proposals. Some costs could be picked up by the Trusts themselves whereas others could be picked up by the Welsh Assembly Government. Work needed to be done to identify which costs would be picked up by which organisations.

Gaynor Jones commented that if Trusts were expected to fund any initiatives individually there could be discrepancies across Wales as some Trusts were financially better off than others.

7. Next Steps

It was agreed that the Taskforce would divide itself into smaller groups in order to further develop the issues identified in Agenda Item 5.

8. Any Other Business

Input of Crown Prosecution and Counter Fraud Security Management Services – It was agreed that representatives from these groups would be invited to attend the main Taskforce meetings.

Medical Input of Occupational Health Specialist- It was agreed that Professor Bisson of the Wales Centre for Health who had done a lot of work in this area would be invited to the main Taskforce Meeting.

9. Dates of Future Meetings

Friday 18 January 2008
Royal College of Nursing Headquarters, Ty Meath, Cardiff
Seminar Room B, 10.00am start 2.00pm finish

Wednesday 13 February 2008
Welsh Assembly Government Building, Cathays Park, Cardiff
Conference Room 3, 10.00am start 2.00pm finish

Monday 10 March 2008
Royal College of Nursing Headquarters, Ty Meath, Cardiff
Seminar Room A, 10.00am start 2.00pm finish
MINUTES OF THE SECOND MEETING OF THE TASKFORCE TO DEAL WITH VIOLENCE AND AGGRESSION IN NHS WALES

10.00AM, FRIDAY 18th JANUARY 2008, SEMINAR ROOM A, ROYAL COLLEGE OF NURSING HEADQUARTERS, TY MEATH, CARDIFF

Present

<table>
<thead>
<tr>
<th>Name</th>
<th>Role/Position</th>
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<tbody>
<tr>
<td>Dave Galligan (Chair)</td>
<td>UNISON</td>
</tr>
<tr>
<td>Jayne Carroll</td>
<td>District Nurse Team Leader, Gwent Healthcare NHS Trust</td>
</tr>
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<td>Gwyneth Pritchard</td>
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<td>Clare Owen</td>
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<td>Chris Beadle</td>
<td>Occupational Health and Safety Policy Lead, NHS Wales, Welsh Assembly Government</td>
</tr>
<tr>
<td>David Wallace</td>
<td>Violence and Aggression Taskforce Coordinator, Welsh Assembly Government</td>
</tr>
<tr>
<td>Angharad Davies</td>
<td>HR Management Trainee, Welsh Assembly Government</td>
</tr>
<tr>
<td>Andrew Cross</td>
<td>BMA Cymru</td>
</tr>
<tr>
<td>Richard Jones</td>
<td>Deputy Director RCN Wales</td>
</tr>
</tbody>
</table>

10. Apologies and Introductions

Apologies were received from Gaynor Jones, A&E Nurse North Glamorgan NHS Trust, Tania Marsden, HR Director, North West Wales NHS Trust, Adrian Williams, Clinical Nurse Specialist, North West Wales NHS Trust, Terry Rose, Director, Wales Health and Safety Executive and Ralph Batten, (Secretariat) Welsh Assembly Government.

Chris Beadle also mentioned that Ian Bellingham, Executive Director, Conwy and Denbighshire NHS Trust would be the Chief Executive representative, Alan Garley would represent GMB and that Superintendent Simon Clarke would be representing the four Welsh Police forces at future meetings.

11. Minutes of the Meeting of 12th December 2007

The minutes of the meeting of 12th December 2007 were agreed after the following amendments:
• Future minutes would have page numbers
• In the attendance list it was noted that Gaynor Jones was actually representing A&E Nursing rather than as an RCN Local Steward as listed.
• Under 4.2 it should have read: “Welsh Ambulance Service Nominee – Chris Beadle reported that Keith Menzies, GMB representative, had an ambulance service background.”
• Under 5.2 Gwyneth Pritchard agreed to provide appropriate wording to reflect discussions at the meeting.
• Under 5.3 the last sentence should have read: “Chris Beadle reported that there would be no problem in the seeking the input of the Counter Fraud Security Management Service in England and there also needed to be interaction with Trade Unions representatives at a local level in NHS England.
• Russell Hoare commented that the previous minutes had not reflected all discussions. It was agreed that the minutes would be a summary of the meeting along with action points agreed.

<table>
<thead>
<tr>
<th>Action Point 1</th>
<th>Gwyneth Pritchard to provide appropriate wording to reflect discussions at the meeting for minute 5.2</th>
<th>Gwyneth Pritchard</th>
</tr>
</thead>
</table>

12. Matters Arising

David Wallace to provide Taskforce members with information on the Violence and Aggression Data he had collected.

3.1.1 David Wallace tabled a report detailing an overview of data for reported violence and aggression incidents. The report showed statistics for the last 3 years and showed a slight reduction in numbers. Despite the feeling that A&E and Ambulance figures would be high, in fact the evidence was not there to support this. David confirmed that the report had given him some thoughts on under-reporting and agreed to explore this further. David also agreed to provide information for the next meeting on the results of the recent staff survey.

3.1.2 Russell Hoare confirmed that in his experiences staff were more likely to report incidents where they feel it will result in action being taken by Trusts.

3.1.3 Richard Jones reported that he had undertaken some observational visits of Trust A&E departments on Saturday nights. He reported that following discussion with the A&E staff they reported large amounts of verbal abuse. Richard further mentioned that he had been party to the Ministers visits to Trusts whereby staff reported that they were less inclined to report minor incidents of verbal abuse as ‘nothing is ever done.’ It was generally reported that all incidents involving physical attack are reported. Staff also felt that some form of ‘fast track’ reporting would work better.
3.1.4 Gwyneth Pritchard reported that several Trusts are moving forward with intranet reporting using their Trust incident reporting software (Datix).

3.1.5 Dave Gallighan stated that confidence needs to be raised with NHS staff about incident reporting and follow up action being taken as a consequence.

3.2 Chris Beadle had previously circulate a copy of the Lone Worker Alert System Business Case to all Taskforce Members

3.2.1 Chris discussed the business case and informed the Taskforce that a sub group of the All Wales Violence and Aggression Steering Group had researched and developed the business case.

3.2.2 Taskforce members congratulated the Sub Group on the business case and agreed that it would form part of the submission to the Minister in July. The Taskforce wished for funding options 1 or 3 in the existing document to be the recommended choice for the Minister to consider.

4 Terms of Reference

4.1 The terms of reference had been amended following the last meeting and circulated to members in advance of the meeting.

4.1.1 Dave Galligan raised comments he had received from Tania Marsden about the amended minutes. Tania had raised the following issues for consideration for additional amendments to the terms of reference:

- No inclusion of an HR Director in the membership of the Taskforce
- Inclusion as an objective that the All Wales Violence and Aggression Training Passport and Information Scheme is complied with.
- Further clarity as to the purpose of the Taskforce as to whether its role is to just advise or actually produce guidelines.
- Further information as to timescales for implementation, reporting and evaluating following the production of the report to the Minister in July 2008.

It was agreed by the Taskforce that only the mention of the inclusion of an HR Director in the membership of the Taskforce would be changed in the terms of reference.

4.2 Following this amendment the terms of reference were agreed and a copy would be circulated with the minutes to all Taskforce members

<table>
<thead>
<tr>
<th>Action Point 2</th>
<th>Amended terms of reference to be circulated with the minutes to all Taskforce members</th>
<th>Ralph Batten</th>
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</thead>
</table>

48
5 A&E – Advice to be provided on action to be taken when people turn up drunk to A&E

5.1 The Minister had requested that this issue be addressed as part of the work of the Taskforce.

5.1.1 Richard Jones informed the Taskforce that he was currently involved in a Group run by Stuart Moncur in the Welsh Assembly Government which is looking at the delivery of emergency care in Wales. Richard informed the Taskforce that this Group were currently addressing the issue of patients and members of the public that turn up at an A&E department either under the influence of alcohol or illicit drugs.

5.2 The Taskforce agreed that it would not duplicate this work and Richard Jones agreed to act as the link between both groups.

<table>
<thead>
<tr>
<th>Action Point 3</th>
<th>Richard Jones to act as the link between the Delivery of Emergency Care Group and the Violence and Aggression Taskforce</th>
<th>Richard Jones</th>
</tr>
</thead>
</table>

6 Incident Reporting: Work of NHS Wales Violence and Aggression Steering Group

6.1 Gwyneth Pritchard circulated a copy of the violence and aggression incident categories which had been developed by the All Wales Violence and Aggression Steering Group.

6.2 The Taskforce agreed the codes were appropriate to the work of the Taskforce and suggested that they be approved with the Minister with the interim report at Easter 2008 for an implementation date with Trusts as 1st April 2008.

<table>
<thead>
<tr>
<th>Action Point 4</th>
<th>Agreement of the Incident Recording Categories and an implementation date of 1st April 2008 to be sought from the Minister when presenting the interim report at Easter 2008</th>
<th>David Wallace</th>
</tr>
</thead>
</table>

7 Results of research on Information Sharing
7.1 It was agreed to combine both Agenda Item 7 and 8 as they both involved information sharing.

7.2 Chris Beadle informed the Taskforce that he would be inviting the Counter Fraud and Security Management Service along to the next meeting to discuss the system they were developing to share information on perpetrators of violence and aggression against NHS Staff in England.

| Action Point 5 | To invite the Counter Fraud and Security Management Service along to the next meeting to discuss the system they were developing to share information on perpetrators of violence and aggression against NHS Staff in England | Chris Beadle |

7.3 David Wallace confirmed that he was meeting with Trade Union colleagues from NHS England to discuss the issues of information sharing protocols the following week. David agreed to provide feedback to the Taskforce following these discussions.

| Action Point 6 | To provide feedback to the Taskforce following meetings with Trade Union colleagues from NHS England to discuss the issues of information sharing protocols | David Wallace |

7.4 Taskforce members were asked again to provide information to David Wallace and Chris Beadle about systems they were aware of that share information of this nature.

| Action Point 7 | All Taskforce members to provide information about systems they were aware of to share information | All |

8 Counselling of Staff who have experienced Traumatic Incidents

8.1 Adrian Williams was not present at the meeting but had previously circulated information about staff support to members of the Taskforce.

8.2 David Wallace tabled a paper on Neuro-linguistic Programming (NLP) as a suggested approach to staff support following traumatic incidents. The Taskforce
thanked David for this work. Claire Owen suggested looking at other public bodies i.e Police, Fire, etc to establish what support mechanisms they have in place. Russell Hoare also mentioned the use of Victim Support.

8.3 It was agreed that a way forward would be to set up a small working party to look at the whole issue of staff support.

8.3.1 It was therefore suggested that a small group be set up consisting of:

- Adrian Williams – North West Wales NHS Trust
- Jayne Carroll – Gwent Healthcare NHS Trust
- Jonathan Bissen – Cardiff and Vale NHS Trust
- Tania Marden – North West Wales NHS Trust
- Jan Hill-Tout – Gwent Healthcare NHS Trust
- Andrew Cross – BMA Cymru
- David Wallace – Welsh Assembly Government

| Action Point 8 | To set up a small working group to produce advice on which approaches the Taskforce should take to address staff support | David Wallace |

9 The Physical Environment: Information on Building Design

9.1 Russell Hoare had previously circulated information about the physical environment to members of the Taskforce.

9.1.1 Russell suggested that as a way of ensuring that these guidance notes are made compulsory for Trusts to use, Welsh Health Estates be introduced into the final sign off of plans for any new constructions or major upgrades.

9.2 It was agreed by the Taskforce that this area be explored further with Welsh Health Estates and it was suggested that Russell Hoare invite a representative from WHE along to the next meeting to discuss options.

| Action Point 9 | To invite a representative from WHE along to the next meeting to discuss options for security of the Physical Environment | Russell Hoare |
10  Membership of Small Groups

10.1 It was agreed by the Task force that two further working groups would be required to address the remaining actions for the Minister. The following two working groups were therefore established:

1. Incident Reporting
   - David Wallace – Welsh Assembly Government
   - Gwyneth Pritchard – Pembrokeshire and Derwen NHS Trust
   - Clare Owen – Health and Safety Executive

<table>
<thead>
<tr>
<th>Action Point 10</th>
<th>To set up a small working group to produce advice on improved incident reporting</th>
<th>David Wallace</th>
</tr>
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</table>

2. Prosecution
   - Chris Beadle – Welsh Assembly Government
   - Chris Woolley – Crown Prosecution Service
   - Simon Clarke – Association of Chief Police Officers (Wales)
   - Richard Jones – Royal College of Nursing (Wales)
   - Andrew Hynes – Welsh Health Legal Services
   - Tim Harrison – Velindre NHS Trust

<table>
<thead>
<tr>
<th>Action Point 11</th>
<th>To set up a small working group to produce advice on prosecutions</th>
<th>Chris Beadle</th>
</tr>
</thead>
</table>

11  Any Other Business

11.1 Chris Beadle informed the Taskforce of the work he had been engaged in with Welsh Health Legal Services and the Crown Prosecution Service (CPS). Chris informed the group that the work would very much support the objectives of the Taskforce, particularly the work of the Prosecution Working Group. Chris further stated that in the opinion of the CPS, to increase the success of prosecutions, more use of good quality CCTV would help. Chris mentioned that he had met with Helen Field, NHS Facilities, Welsh Assembly Government and David Wallace to discuss options for better provision of CCTV in healthcare premises in NHS Wales. Chris agreed to ensure that the findings from this meeting would feed into the work of the Prosecution Group.
12 Date and Time of Next Meeting

Wednesday 13 February 2008
Welsh Assembly Government Building, Cathays Park, Cardiff
Conference Room 3, 10.00am start 2.00pm finish
MINUTES OF THE THIRD MEETING OF THE TASKFORCE TO DEAL WITH VIOLENCE AND AGGRESSION IN NHS WALES

10.00AM, WEDNESDAY 13 FEBRUARY 2008, CONFERENCE ROOM 3, WELSH ASSEMBLY GOVERNMENT BUILDING, CATHAYS PARK, CARDIFF

Present

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation/Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dave Galligan (Chair)</td>
<td>UNISON</td>
</tr>
<tr>
<td>Ian Bellingham</td>
<td>Executive Director, Conwy &amp; Denbighshire NHS Trust</td>
</tr>
<tr>
<td>Paul Gage</td>
<td>GMB</td>
</tr>
<tr>
<td>Tim Harrison</td>
<td>Chair, NHS Wales Health and Safety Advisers Forum</td>
</tr>
<tr>
<td>Gaynor Jones</td>
<td>A &amp; E Nursing, North Glamorgan NHS Trust</td>
</tr>
<tr>
<td>Richard Jones</td>
<td>Deputy Director, Royal College of Nursing Wales</td>
</tr>
<tr>
<td>Tania Marsden</td>
<td>HR Director, North West Wales NHS Trust</td>
</tr>
<tr>
<td>Clare Owen</td>
<td>HM Inspector, Health and Safety Executive Wales</td>
</tr>
<tr>
<td>Terry Rose</td>
<td>Director, Health and Safety Executive Wales</td>
</tr>
<tr>
<td>Gwyneth Pritchard</td>
<td>Chair, All Wales Violence and Aggression Steering Group</td>
</tr>
<tr>
<td>Erica Stamp</td>
<td>Assistant Secretary, BMA Wales</td>
</tr>
<tr>
<td>Chris Beadle</td>
<td>Occupational Health and Safety Policy Lead, NHS Wales, Welsh Assembly Government</td>
</tr>
<tr>
<td>David Wallace</td>
<td>Taskforce Manager, Welsh Assembly Government</td>
</tr>
<tr>
<td>Angharad Davies</td>
<td>HR Management Trainee, Welsh Assembly Government</td>
</tr>
<tr>
<td>Ralph Batten (Secretariat)</td>
<td>Executive Officer to Occupational Health and Safety Policy Lead, NHS Wales</td>
</tr>
</tbody>
</table>

1. Apologies

Apologies were received from Jayne Carroll, District Team Leader, Gwent Healthcare NHS Trust, Peter Finch, CSP, Martin Wiles, Counter Fraud Security Management Service, Nigel Davies, Welsh Health Estates and Superintendent Simon Clarke, Operational Commander, South Wales Police.

The Taskforce expressed its disappointment at Superintendent Clarke’s absence for the second meeting running. Chris Beadle reported that there was a representative from the four Welsh Police Forces seconded to work for the Welsh Assembly
Government. If Superintendent Clarke continued to send his apologies, Mr Beadle would ask the WAG Police secondee to serve as a member of the Taskforce instead. Taskforce members agreed on this course of action.

| Action Point | To ask the Welsh Assembly Government Police Secondee to serve as member of the Taskforce instead of Superintendent Clarke if he continued to send his apologies | Chris Beadle |

2. Minutes of last meeting

The Minutes were accepted as an accurate record of proceedings.

3. Matters Arising

Provision of Appropriate Wording to reflect discussions at the meeting for minute 5.2

Gwyneth Pritchard reported that she had provided the appropriate wording.

Amended Terms of Reference to be circulated with the Minutes to all Taskforce Members

It was confirmed that the Terms of Reference had been circulated with the Minutes.

3.3 Links Between Delivery of Emergency Care Group and Violence and Aggression Taskforce

Richard Jones reported that the Delivery of Emergency Care Group was in the process of identifying mechanisms to record those arriving in A&E Departments drunk and on drugs. He would e-mail Stuart Moncur of the Welsh Assembly Government who ran the group to ascertain the exact nature of this work.

| Action Point | To e-mail Stuart Moncur to ascertain the nature of the work of the Emergency Care Group in the area of identifying mechanisms to record those arriving drunk and on drugs in A&E Departments and report back to the next Taskforce Meeting | Richard Jones |

3.4 Agreement of the Incident Reporting Categories

David Wallace reported that the Categories had been agreed and they would be
implemented on an all – Wales basis on 1 April.

3.5 Membership of Small Groups
Post Meeting Note – The Staff Support Sub – group would meet on Monday 3 March 2008 at the Atrium, University of Glamorgan, Adam Street, Cardiff at 10.30am and the Prosecutions Sub – group would meet on Thursday 28 February 2008 at the Royal College of Nursing Headquarters, Ty Maeth, Cardiff at 2.00pm.

4. Agree Terms of Reference

The Chair suggested that if colleagues were content, the Terms of Reference could now be signed off.

It was noted that the GMB representative was not included in the Membership List. The Chair reported that this had been a late co-option by the Health Minister’s Office.

Chris Beadle agreed to update the Terms of Reference and re-submit them to the Health Minister for her consideration at Easter at the same time as the Interim Report.

<table>
<thead>
<tr>
<th>Action Point</th>
<th>To update the Terms of Reference and re-submit them to the Health Minister for consideration at Easter at the same time as the Interim Report</th>
<th>Chris Beadle</th>
</tr>
</thead>
</table>

5. Information Sharing System Developed by the Counter Fraud and Security Management Service (CFSMS)

The Chair expressed his disappointment that Mr Wiles from the Counter Fraud and Security Management Service had failed to attend the meeting.

Instead, it was agreed that the Chair, Chris Beadle and David Wallace would meet with Mr Wiles at his office before the next meeting of the Taskforce on 10 March.

<table>
<thead>
<tr>
<th>Action Point</th>
<th>To meet with Martin Wiles to discuss the Information Sharing System developed by the CFSMS and report back to the next Taskforce meeting</th>
<th>Chair / Chris Beadle / David Wallace</th>
</tr>
</thead>
</table>


Not Discussed.

7. Information Sharing Systems provided by Taskforce Members
Not Discussed.

8. **Options for the Security of the Physical Environment**

This item was not discussed as the representative from Welsh Health Estates was not in attendance.

The Chair confirmed that the discussion would centre around the Design of New Hospital Buildings and the modification of existing ones in terms of a safer physical environment.

9. **Any Other Business**

9.1 **General Discussion on Violence and Aggression in NHS Wales**

- **Background**
  Chris Beadle reported that the Taskforce was established by the Minister for Health and Social Services in response to her discussions with Tina Donnelly, RCN and the Dave Galligan, UNISON and also as a result of her recent visits to NHS Trusts in Wales where the issue of Violence and Aggression was high on the agenda. From her visits, the Minister had concluded that incident reporting and post incident support to victims of violent incidents were poor.

- **Membership of Taskforce**
  Chris Beadle reported that he and David Wallace had met with the Minister to discuss the Membership of the Taskforce. He confirmed that representatives from the Police and the Crown Prosecution Service were included in the initial membership list but the Minister had decided not to invite them at that stage. She had instead decided that they would only be invited as and when they were needed.

- **Recommendations and Timescales**
  David Wallace reported that the themes which would be identified in the report were taken from the Ministerial Statement on Violence and Aggression made to plenary in October 2007. The Taskforce was tasked to provide the Minister with an interim report by Easter 2008 and its final report by the summer of 2008. Mr Wallace further confirmed that the role of the Taskforce was to make recommendations but it was up to the Health Minister to decide whether or not to accept them.

- **Domestic Violence**
  The Chair reported that the Taskforce was not remitted to cover Domestic Violence. Terry Rose commented that the issue of Domestic Violence could be relevant in the case of Lone Workers and that he would welcome the input of the Police in this area. It was recommended that the final report’s recommendations should recommend that a further piece of work needed to be done in the area of domestic violence.

- **Monitoring of Recommendations**
  The Chair confirmed that any recommendations made by the Taskforce would need to be monitored. He understood that the Health Minister intended to build the recommendations into Performance Management Targets.
Public Education Campaign
Chris Beadle reported that a huge public education campaign would form part of the final roll-out of the report’s recommendations.

Involvement of the Primary Care Sector
Chris Beadle commented that the current membership structure of the Taskforce was Trust focused and engagement was needed with the Primary Care Sector as the final report would have a huge impact on them. It was noted that there was no Primary Care representative serving as a member of the Taskforce. Ralph Batten would ask Geoff Lang to nominate a suitable representative. David Wallace suggested that the Minister would have to take into account the different healthcare settings when applying the report’s recommendations. The Chair commented that that only one document with standard principles would be needed. The document would deal with the scope of the project and it should be recognised that different healthcare settings had different needs. David Wallace further suggested that a sentence saying that further work was needed in this area should be included in the final report and recommendations.

<table>
<thead>
<tr>
<th>Action Point</th>
<th>To contact Geoff Lang to seek a suitable Primary Sector nomination to serve as a member of the Taskforce</th>
<th>Ralph Batten</th>
</tr>
</thead>
</table>

Cost Implications
David Wallace confirmed that the Taskforce was not remitted to consider cost implications. The final decision regarding cost implications rested with the Health Minister.

A Police Presence at all A&E Departments
Chris Beadle suggested placing in the Interim Report a recommendation that there should be a Police presence at all A&E Departments.


The recommendations were tabled by David Wallace. He explained that one of the key themes identified by the Health Minister for consideration was the reporting of incidents. A review of available data suggested a significant under-reporting of incidents and the group considered how staff could be encouraged to report, how it can be made easier to report and how to develop better systems of reporting.

The following issues were raised:

No mention of Local Health Boards
David Wallace confirmed that the recommendations in the final report would
embrace the whole NHS family.

**Mandatory Violence and Aggression Passport Training must be undertaken**
**At commencement of employment on Day 1**

Gaynor Jones asked how this would be achieved. David Wallace explained that the load would be spread by providing training through universities. The group had worked on the principle that the exposure of the employee to risks from day 1 was unacceptable. The group had decided not to adopt a total e-learning approach as there were personal elements contained within the Passport. It was up to the Taskforce to make recommendations on this issue and for Minister to make decisions based on these recommendations.

**Modules A & B of the Passport Scheme should be mandatory for all staff without exception**

Gwyneth Pritchard reported that Module A was incorporated into the Corporate Health and Safety E-learning package. Module A would be addressed at Induction on Day 1.

**Why is there under –reporting ?**

David Wallace explained that the reason for this was that staff in A & E Departments felt that incidents of verbal aggression were almost the norm and that they were not worth reporting. He further explained that the Reporting Group had discussed placing the emphasis on staff to report and that it should be a disciplinary offence not to do so. It was the intention that the Taskforce would produce standard guidance and policy similar to the recently developed Dignity at Work Policy. Erica Stamp drew the Taskforce’s attention to a recently published BMA document on the reporting of violent incidents which showed that women were most likely to report violent incidents. Fifty –two per cent had said that no action had been taken as a result of their report and many were unaware as to whom they should report the incident to. Only twenty per cent had received post incident support. She would e-mail a copy the document to Ralph Batten for him to distribute to Taskforce Members.

<table>
<thead>
<tr>
<th>Action Point 1</th>
<th>To e-mail a copy of the BMA Incident Reporting document to Ralph Batten</th>
<th>Erica Stamp</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action Point 2</td>
<td>To distribute the BMA Incident Reporting document to all Taskforce Members</td>
<td>Ralph Batten</td>
</tr>
</tbody>
</table>

**Modules C&D of the Passport Scheme should be mandatory for staff in specific working areas (eg Mental Health) and subject to specific risk assessment**

Chris Beadle reported that the All Wales Violence and Aggression Group were looking at research into Breakaway Training as it was not as effective as first thought.
Next Steps
It was agreed that all Taskforce Members would provide comments on the draft recommendations in time for the next Taskforce meeting on 10 March.

| Action Point | To provide comments on the draft recommendations of the Reporting Group in time for the next Taskforce meeting on 10 March | All Taskforce Members |

10. Date of Next Meeting

Monday 10 March 2008
Royal College of Nursing Headquarters
Ty Maeth,
King George V Drive East
Cardiff
Seminar Room A,
10.00am start 2.00pm finish
## Appendix G

### All Wales Violence and Aggression Incident Recording Codes

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violence and Aggression</td>
<td>Any incident where staff are abused, threatened or assaulted in circumstances relating to their work, involving explicit or implicit challenge to their safety, well-being or health. This can incorporate some behaviour identified in harassment and bullying, for example verbal violence.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abduction/Kidnap/Hostage</td>
<td>To take somebody away by force or deception</td>
</tr>
<tr>
<td>Sexual Harassment/Assault</td>
<td>The making of unwanted sexual advances or remarks to a person, especially at work</td>
</tr>
<tr>
<td>Indecent Exposure</td>
<td>The act or offence of indecently exposing one's body, especially the genitals, to public view.</td>
</tr>
<tr>
<td>Robbery</td>
<td>The act or an instance of illegally taking something that belongs to somebody else, especially by using force, threats, or violence</td>
</tr>
<tr>
<td>Rape</td>
<td>When a man has sexual intercourse (vaginal or anal) or oral sex with a woman or another man who does not consent and at the time he is aware that consent had not been given, or is reckless as to whether consent had been given.</td>
</tr>
<tr>
<td>Self Harm</td>
<td>The act or an instance of harming oneself which can result in injury or death.</td>
</tr>
<tr>
<td>Deliberate Damage</td>
<td>When a person without lawful excuse destroys or damages any property belonging to the individual or another intending to destroy or damage it, or being reckless as to whether it is destroyed or damaged.</td>
</tr>
<tr>
<td>Telephone Rage</td>
<td>Where an individual exhibits intense uncontrolled anger or fury over the telephone</td>
</tr>
<tr>
<td>Racial Abuse</td>
<td>Abusive or aggressive behaviour relating to relations or differences between races.</td>
</tr>
<tr>
<td>Homophobic Abuse</td>
<td>Abusive or aggressive behaviour relating to sexual orientation.</td>
</tr>
<tr>
<td>Unsolicited Mail/Email</td>
<td>When a person sends a letter, email or article which conveys a message that is indecent or threatening, with the intention of causing distress or anxiety to the recipient or to another person to whom it is intended, that the message should be communicated.</td>
</tr>
<tr>
<td>Aggressive/Threatening Behaviour – Patient to Patient</td>
<td>When a patient threatens another patient intending them to fear that the threat would be carried out. A threat is an expression of an intension to punish, hurt or</td>
</tr>
<tr>
<td>Aggressive/Threatening Behaviour – Patient to Staff</td>
<td>When a patient threatens a member of staff intending them to fear that the threat would be carried out. A threat is an expression of an intension to punish, hurt or harm.</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Aggressive/Threatening Behaviour – Patient to Relative/Visitor/Member of the Public</td>
<td>When a patient threatens a relative/visitor intending them to fear that the threat would be carried out. A threat is an expression of an intension to punish, hurt or harm.</td>
</tr>
<tr>
<td>Aggressive/Threatening Behaviour – Staff to Patient</td>
<td>When a member of staff threatens a patient intending them to fear that the threat would be carried out. A threat is an expression of an intension to punish, hurt or harm.</td>
</tr>
<tr>
<td>Aggressive/Threatening Behaviour – Staff to Staff</td>
<td>When a member of staff threatens another member of staff intending them to fear that the threat would be carried out. A threat is an expression of an intension to punish, hurt or harm.</td>
</tr>
<tr>
<td>Aggressive/Threatening Behaviour – Staff to Relative/Visitor/Member of the Public</td>
<td>When a member of staff threatens a relative/visitor intending them to fear that the threat would be carried out. A threat is an expression of an intension to punish, hurt or harm.</td>
</tr>
<tr>
<td>Aggressive/Threatening Behaviour – Relative/Visitor/Member of the Public to Relative/Visitor/Member of the Public</td>
<td>When a relative/visitor threatens a relative/visitor intending them to fear that the threat would be carried out. A threat is an expression of an intension to punish, hurt or harm.</td>
</tr>
<tr>
<td>Aggressive/Threatening Behaviour – Relative/Visitor/Member of the Public to Patient</td>
<td>When a relative/visitor threatens a patient intending them to fear that the threat would be carried out. A threat is an expression of an intension to punish, hurt or harm.</td>
</tr>
<tr>
<td>Aggressive/Threatening Behaviour – Relative/Visitor/Member of the Public to Staff</td>
<td>When a relative/visitor threatens a member of staff intending them to fear that the threat would be carried out. A threat is an expression of an intension to punish, hurt or harm.</td>
</tr>
<tr>
<td>Assault – Patient to Patient</td>
<td>A physical attack from patient to patient.</td>
</tr>
<tr>
<td>Assault – Patient to Staff</td>
<td>A physical attack from patient to staff.</td>
</tr>
<tr>
<td>Assault – Patient to Relative/Visitor/Member of the Public</td>
<td>A physical attack from patient to relative/visitor/member of the public.</td>
</tr>
<tr>
<td>Assault – Staff to Patient</td>
<td>A physical attack from staff to patient.</td>
</tr>
<tr>
<td>Assault – Staff to Staff</td>
<td>A physical attack from staff to staff.</td>
</tr>
<tr>
<td>Assault – Staff to</td>
<td>A physical attack from staff to relative/visitor/member of the</td>
</tr>
<tr>
<td>Relative/Visitor/Member of the Public</td>
<td>public.</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Assault – Relative/Visitor/Member of the Public to Relative/Visitor/Member of the Public</td>
<td>A physical attack from relative/visitor/member of the public to relative/visitor/member of the public.</td>
</tr>
<tr>
<td>Assault – Relative/Visitor/Member of the Public to Patient</td>
<td>A physical attack from relative/visitor/member of the public to patient.</td>
</tr>
<tr>
<td>Assault – Relative/Visitor/Member of the Public to Staff</td>
<td>A physical attack from relative/visitor/member of the public to staff.</td>
</tr>
<tr>
<td>Verbal Abuse – Patient to Patient</td>
<td>Patient speaks to a patient in an insulting and offensive way.</td>
</tr>
<tr>
<td>Verbal Abuse – Patient to Staff</td>
<td>Patient speaks to a member of staff in an insulting and offensive way.</td>
</tr>
<tr>
<td>Verbal Abuse – Patient to Relative/Visitor/Member of the Public</td>
<td>Patient speaks to a relative/visitor in an insulting and offensive way.</td>
</tr>
<tr>
<td>Verbal Abuse – Staff to Patient</td>
<td>A member of staff speaks to a patient in an insulting and offensive way.</td>
</tr>
<tr>
<td>Verbal Abuse – Staff to Staff</td>
<td>A member of staff speaks to another member of staff in an insulting and offensive way.</td>
</tr>
<tr>
<td>Verbal Abuse – Staff to Relative/Visitor/Member of the Public</td>
<td>A member of staff speaks to a relative/visitor in an insulting and offensive way.</td>
</tr>
<tr>
<td>Verbal Abuse – Relative/Visitor/Member of the Public to Relative/Visitor/Member of the Public</td>
<td>A relative/visitor speaks to another relative/visitor in an insulting and offensive way.</td>
</tr>
<tr>
<td>Verbal Abuse – Relative/Visitor/Member of the Public to Patient</td>
<td>A relative/visitor speaks to a patient in an insulting and offensive way.</td>
</tr>
<tr>
<td>Verbal Abuse – Relative/Visitor/Member of the Public to Staff</td>
<td>A relative/visitor speaks to a member of staff in an insulting and offensive way.</td>
</tr>
<tr>
<td>Other</td>
<td>Any other incident not described above.</td>
</tr>
<tr>
<td>Sub-Category</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Smoking Related</td>
<td></td>
</tr>
<tr>
<td>Drug Related</td>
<td></td>
</tr>
<tr>
<td>Alcohol Related</td>
<td></td>
</tr>
<tr>
<td>Medical Condition</td>
<td></td>
</tr>
<tr>
<td>Mental Condition</td>
<td></td>
</tr>
<tr>
<td>Weapon Involved</td>
<td></td>
</tr>
<tr>
<td>Racially Motivated</td>
<td></td>
</tr>
<tr>
<td>Religion Motivated</td>
<td></td>
</tr>
<tr>
<td>Graffiti Motivated</td>
<td></td>
</tr>
<tr>
<td>Noise Nuisance</td>
<td></td>
</tr>
<tr>
<td>Breaking Bad News</td>
<td></td>
</tr>
<tr>
<td>Stress Related</td>
<td></td>
</tr>
<tr>
<td>Homophobic Related</td>
<td></td>
</tr>
</tbody>
</table>

**Extra Fields Box required for:**

**Working Alone** – required as a standard question for all incidents with a yes/no response.

**List of Weapons** – Gun, Knife, Crossbow, Screwdriver, Needle, Bomb, knuckle-duster, club/bat. Only required once answered yes to Weapons Involved in the Sub-Category.

**Police Involvement** – did we inform police. Crime number.

**Restraint** – was this required at any stage.
Appendix H

All-Wales Violence and Aggression Passport
ALL WALES NHS VIOLENCE AND AGGRESSION TRAINING PASSPORT AND INFORMATION SCHEME
FOREWORD

The *All Wales NHS Violence and Aggression Training Passport and Information Scheme* is the second such scheme that has been developed by the NHS in Wales. The project is based on partnership and signifies the coming together of NHS organisations, staff organisations and the Health and Safety Executive within Wales to work towards a shared vision.

The risks that staff are exposed to as a result of violence and aggression have been well publicised and it is important that NHS employers do all that they can to deal with the problem. This Scheme will, in time, lead to a more effective use of resource, consistency in methods to tackle violence and aggression and improvements in the health and wellbeing of staff.

The key to the success of this initiative is the involvement of all those who have an interest in preventing the exposure of staff and patients to verbal and physical aggression. This includes:

- Trust/Local Health Board Boards who should review their current prevention strategies and ensure that they meet the minimum standards laid out in this document.
- Local managers who must ensure that they consider the welfare of their staff and other patients as an integral part of their management role.
- Employees who must practice safely at all times and report on any difficulties they may be having. They must also report any acts of physical or verbal aggression to which they are exposed, and
- Advisors within Trusts/Local Health Boards must ensure that they provide accurate and timely advice when required.
On behalf of the Welsh Assembly Government and the Health and Safety Executive we welcome this second initiative as a signal of yet more good work and collaboration that is taking place within the NHS in Wales and look forward to monitoring its progress over the forthcoming years.

Signed

Jane Hutt
Minister for Health and Social Services
Welsh Assembly Government

Terry Rose
Director Wales
Health and Safety Executive

Ann Lloyd
Head of Health and Social Care Department
Chief Executive NHS Wales
INTRODUCTION TO THE ALL WALES NHS VIOLENCE AND AGGRESSION TRAINING PASSPORT AND INFORMATION SCHEME

What is the Passport Scheme?

The All Wales NHS Violence and Aggression Training Passport and Information Scheme provides a framework for the delivery of violence and aggression training within the NHS in Wales. It also provides guidance on the development of documentation to ensure the effective assessment and management of violence and aggression.

The overall aim of the Scheme is to ensure consistent standards of documentation and training within the NHS. This will reduce the need for retraining and represent a considerable saving in training time and resource.

Have similar Schemes previously been developed?

In January 2003 the All Wales NHS Manual Handling Training Passport and Information Scheme was launched. This represented the culmination of work that had been undertaken by manual handling professionals within Welsh NHS Trusts. The success of this Scheme prompted a call to develop a similar scheme for violence and aggression. Like manual handling, violence and aggression presents a significant risk to the NHS in Wales. All NHS employers have to assess the risk that violence and aggression presents and ensure that they equip staff to deal with that risk.

Similar schemes are also already well established in the Construction Industry where there is a core workforce moving from employer to employer.

Background

The Scheme has been developed by the All Wales NHS Steering Group for the Management of Violence and Aggression. The first meeting of the Group took place in May 2003. The membership of the group is multidisciplinary and it is made up of:-

- at least one representative of NHS Trusts in Wales and the Powys Local Health Board
a representative of the Health and Safety Executive
a representative of the Welsh Assembly Government
a representative of the Royal College of Nursing, and
a representative of the British Medical Association.

The membership of the group represents a number of stakeholders who have an interest in the effective management of violence and aggression.

The Group was established as it is recognised that there is a significant risk to staff working in the NHS as a result of incidents of violence and aggression. On the 14 October 1999 the NHS Zero Tolerance Zone Campaign was formally launched. The aims of the cross-Government campaign are:-

- to get over to the public that violence against staff working the in the NHS is unacceptable and the Government (and the NHS) is determined to stamp it out;
- to get over to all staff that violence and intimidation is unacceptable and is being tackled.

Employers are required to develop policies, procedures and documentation which will help to identify and manage the risk of violence and aggression. As the basic information for this documentation is common from employer to employer it was decided to develop proforma documentation to assist NHS employers in Wales and to cut down on duplication.

**What is Violence and Aggression?**

For the purposes of this Scheme violence and aggression is defined as:-

*Any incident where staff are abused, threatened or assaulted in circumstances relating to their work, involving explicit or implicit challenge to their safety, well-being or health. This can incorporate some behaviours identified in harassment and bullying, for example verbal violence.*
Why is it necessary?

Nurses and other healthcare workers face an increased risk of violence and aggression. The general increase in violence in society is compounded by problems of substance misuse and use of weapons. The 2002/2003 British Crime Survey found that 5% of Health and Social Welfare professional, including nurses and doctors, had experienced work-related violence and aggression. This statistic does not include verbal aggression.

Under the Health and Safety at Work etc Act 1974 and the Management of Health and Safety at Work Regulations 1999 employers have a duty to ensure the health, safety and welfare of their staff. Where they may be at risk this must be assessed, documented and staff provided with adequate information, instruction and training.

The Health and Safety Executive within Wales have highlighted the issue during audits and inspections that they have undertaken of NHS Trusts and Local Health Boards. Between April 1996 and March 2004 they served 16 improvement notices on NHS Trusts relating to the management of violence and aggression.

The measures which can be introduced to control this risk are common across the NHS. It therefore makes good sense to share resource and work together.

The NHS invests a considerable amount of resource in a variety of different levels of training. If staff leave their employer this training is often lost as their new employer will retrain them. As the vast majority of staff leaving an NHS employer move to a neighbouring NHS employer within Wales it would be beneficial to allow them to transfer their training skills, minimising duplication and time lost to the service.

What are the aims and objectives of the Scheme?

The aims and objectives of the scheme are:-

- To ensure consistency in violence and aggression training/assessment within participating Trusts and Local Health Boards.
To develop a mechanism whereby skills can be transferred between participating Trusts and Local Health Boards.

To ensure the sharing of resource to minimise duplication within participating Trusts and Local Health Boards.

Who will monitor the Scheme?

The All Wales NHS Steering Group for the Management of Violence and Aggression (The Steering Group) will continue to meet after the implementation of the Scheme to ensure its integrity and effectiveness.

Material provided within the ‘Passport’ will be constantly reviewed and updated to ensure that it remains in line with legislation and best practice.

New material/information will be added as and when required by legislation and best practice. At the time of writing this first edition a number of further initiatives are being developed.

It is important that managers in the workplace monitor the Scheme on a day-to-day basis by:

- Asking staff about their work
- Checking whether staff are behaving in a manner that will encourage the most appropriate management of violence and aggression.
- Reviewing incidents that occur to ensure that they have been managed effectively, to identify trends and to ensure that staff and service users are supported.

What is the legal position?

The ultimate responsibility for the health and safety of staff rests with the employing organisation. This position is re-enforced in both criminal and civil law.

The participation in the Scheme, does however, signify an organisations willingness to educate and train their staff to a consistent standard.
Participation in the Scheme sets an approved national standard against which NHS employers in Wales can be judged. This has been welcomed by the Health and Safety Executive and Trust legal advisors.

Note: The material contained within this pack was up-to-date at the time of going to press.

Can other organisations use the pack?

Whilst the Scheme was developed with the NHS in Wales in mind it represents best practice and could equally be applicable in other care situations.

What does this pack contain?


It is important that NHS organisations recognise the need for training standards in violence and aggression. There is a legal requirement to ensure that those advising and training others in the safe management of violence and aggression have the appropriate skills and knowledge.

This section outlines the skills required to undertake violence and aggression training. It recognises that training may consist of differing elements and that the skills will therefore vary depending on the level of training provided. Participating Trusts and Local Health Boards should consider the current level of expertise of those providing advice and training and, where employed by the Trust or Local Health Board, their subsequent professional development needs.

This section also outlines the standards for provision of adequate training facilities.

Part 2: Therapeutic Management of Violence and Aggression Course Aims and Objectives

This section outlines the aims and objectives of the Schemes training programme.
The training programme is broken down into modular sections to allow for flexibility in its delivery.

The section, at present provides guidance on the content of 3 different levels of training as follows:

- Module A – Induction and Awareness Raising
- Module B – Theory of Personal Safety and De-escalation
- Module C – Breakaway

A fourth module, Module D which will deal with Physical Intervention Training is currently being considered.

When comparing current training content this was the area of greatest variance. However, due regard is being paid by the NHS Trusts and Local Health Boards to the Mental Health Act Code of Practice (1999), Nursing and Midwifery Council Guidelines of the Therapeutic Management of Violence and Aggression and the legal position relating to the use of reasonable force.

The Group will start to consider this module, in doing so it will take account of the great deal of work that is already underway. The Children and Families Division within the Welsh Assembly Government is developing the Framework for Restrictive Physical Intervention Policy and Practice and the publication of the National Institute for Clinical Excellence (NICE) Guidelines on the Short Term Management of Disturbed (Violent) Behaviour in Psychiatric Inpatients is awaited.

At the time of going to press there was no accredited training available in the management of violence and aggression which is specific to the needs of healthcare. The Steering Group will continue to monitor this position.

**Part 3: Records of Training**

This section provides standard documents for recording training and achievements of course participants.

This information will transfer with the employee if they move from employer to employer.
**Part 4: Violence and Aggression Risk Assessment Forms**

This section provides risk assessment forms for assessment of tasks/environments where there may be a risk of violence and aggression.

At present individual patient assessments are not incorporated into the documentation. It is felt that this area is generally well represented with documents such as the Functional Assessments and Care Environments (FACE) risk assessment tools and a number of other documents. It is intended in future documents to provide basic guidance on the content of an individual patient assessment for areas that do not already have this documentation.

**Part 5: Guidelines for Protecting NHS Staff from Violence and Aggression**

Employees as well as patients' have rights under the Articles of the Human Rights Act 1998 and these must be respected. The important rights when considered in the context of violence and aggression are as follows:

- Article 2 ‘Right to Life’
- Article 3 ‘Prohibition of inhumane or degrading treatment’
- Article 8 ‘Right to Respect for Private and Family Life’
- Article 14 ‘Prohibition of Discrimination’.

It is important that mutual respect is shown between employees, patients and their relatives/carers. However, Trusts and Local Health Boards will, after giving consideration to all other options, seek to exclude patients and relatives from their premises where acts of violence and aggression towards staff becomes unacceptable. This action would not be undertaken lightly. Under such circumstances a decision may be made to serve a Patient Undertaking. This explains to the patient that their behaviour has been unacceptable and it specifies what is expected of them. If they do not meet the needs of the Patient Undertaking they may be excluded from the premises and advised that they will only receive emergency treatment. A template for developing such a document is contained within the Scheme. Legal advice has been sought from Morgan Cole Solicitors in the development of the guidance.
Part 6: Lone Working

A number of NHS staff routinely work alone, others may do so infrequently due to particular circumstances. Employees that work alone are more vulnerable to violence from members of the public. Furthermore lone working may mean that there are additional difficulties in obtaining assistance in the event of an incident such as accidents or vehicle breakdowns.

Two documents are contained within the Scheme to provide guidance to Trusts and Local Health Boards where there is lone working, they are:

- A Proforma Lone Worker Policy which NHS employers can adapt to suit their needs and,
- Specification for a Lone Worker Alert System.

Future Additions

It is intended to add information to the Scheme as and when it becomes available. Amendments will be made available as appropriate.
PART 1: MANAGEMENT OF VIOLENCE AND AGGRESSION TRAINING GUIDELINES

1. Introduction

1.1 There has been a growing recognition of the need for standards associated with both the actual delivery and course content of training in the management of violence and aggression.

1.2 Whilst professional guidelines provide general advice on the management of violence and aggression in the workplace this passport scheme provides employers with specific guidelines for the provision of training. The scheme is intended to assist employers in ensuring that employees receive a minimum standard of training, which will lead to competence in the management of potential and actual incidents of violence and aggression.

1.3 To ensure compliance with the standards identified in this scheme employing organisations will need a robust training and education programme for all employees. Those involved in the provision of training must be appropriately skilled and qualified to deliver the programme identified within this scheme.

1.4 Employing organisation will need to ensure that a strategy for recall and update training is put in place. Any recall strategy will need to reflect the underpinning environmental and clinical risk assessments undertaken across the organisation.

2. Why are standards needed?

- To reduce the risks to patients, visitors and employees from poor practices.
- To provide protection for employers and all employees.
- To ensure effective and efficient use of resources (manpower and time).
- To promote consistent, best practice through the development of transferable skills.
- To ensure compliance with the law.
3. **What are the pre-training requisites?**

- There must be a comprehensive training needs analysis across the organisation to identify what training is required. This will be informed by risk assessment.
- There must be specific policies and procedures in place to support employees and patient safety and promote best practice.
- The senior management team of the organisation must fully endorse the training strategy developed to support effective safe management of violence and aggression.
- Sufficient resources must be allocated within the organisation to facilitate the delivery of adequate levels of training and implement practice in accordance with agreed policies and procedures.
- Individuals undertaking the role of trainer in the management of violence and aggression must be competent trainers in accordance with the defined specification.
- Consideration must be given to ensuring the safety and well being of all employees participating in the management of violence and aggression. This can be achieved by:
  
  - Provision of timely occupational health advice to both employees and managers.
  - Employee awareness of the need to report any restrictions which may impede their ability to undertake practical techniques associated with the management of violence and aggression.
  - Adequate facilities to provide skilled debriefing and support following incidents of violence and aggression.
  - A mechanism which facilitates feedback from trainers to managers to ensure that specific issues relating to individuals or the collective group in training the various modules are brought to the manager’s attention.

4. **Identifying a Trainer**

4.1 For training in the management of violence and aggression to be effective all training must be delivered by knowledgeable and credible trainers.
4.2 Whilst person specifications for trainers delivering the various modules (Induction to Module C) have been provided below, it is for the employing organisation to determine whether the individual appointed to provide the training meets the specification and is deemed to be an appropriate individual to undertake the role.

4A. **Person Specification A : Induction & Awareness**

Presentation skills:

- Must be able to demonstrate ability to deliver a presentation.
- Must be able to demonstrate an understanding of local health and safety policies and procedures relevant to the management of violence and aggression.
- Must be able to translate theoretical knowledge of the subject matter into an appropriate healthcare context.
- Must be able to demonstrate an up to date knowledge of relevant health and safety legislation.
- Must be able to demonstrate a working knowledge and understanding of the cultural/societal issues associated with violence and aggression.
- Must be able to demonstrate an understanding of the organisation’s structure and management arrangements.

4B. **Person Specification B : Talkdown and Breakaway**

- Must have a recognised training qualification or be able to demonstrate experience up to City and Guilds 730/NVQ equivalent/Certificate in Education.
- Must be able to demonstrate up to date knowledge of relevant literature and professional guidelines associated with the management of violence and aggression.
- Must be able to demonstrate up to date knowledge of relevant legal issues.
- Must be able to translate theoretical knowledge of the subject matter into appropriate healthcare context with knowledge of practical application.
- Must be physically capable of demonstrating good practice.
- Must be able to demonstrate/identify the mechanism for keeping abreast of developments in the field.
- Must be able to demonstrate a working knowledge and understanding of the professional codes of practice of the employees receiving training.
- Must be able to demonstrate an understanding of risk assessment processes within a healthcare setting.
5. **Organisation and Implementation of Training**

5.1 Training must be available to all employees who require it.

5.2 Training provision must be based upon risk assessment.

5.3 The training facility must be risk assessed for suitability giving consideration to the training to be provided.

5.4 Practical skills training must be safe and sufficiently supervised. Consideration will need to be given to:

- Size and layout of the training venue
- The techniques to be performed
- The equipment available (mats, chairs, beds etc)

5.5 Consideration will be given to the availability and access to a First Aider/First Aid facilities.

5.6 There will be a minimum of one trainer to eight trainees when practical manoeuvres are being demonstrated and practised eg, during breakaway.

6. **Planning and recording of training**

6.1 Training must meet the needs of participants and the organisation.

6.2 Duration of training must be sufficient to support and develop knowledge, attitude and skills. Demonstrations alone are not sufficient for practical skills training. Employees must have sufficient time to practice taught skills under close supervision of the allocated trainer.

6.3 If an employee attends a module and is unable to participate in any part of the training eg, due to a health related issue etc, all aspects of non-participation must be clearly recorded on the attendance record. This information must also be shared with their service manager.

6.4 Attendance at training sessions must be recorded. Feedback on employee attendance, ability and issues of concern regarding performance at training sessions must be provided to service managers.
6.5 A robust system for recall and update training must be in place. Frequency and level of update training will be determined by risk assessment.

6.6 Reasons for non-attendance at training sessions must be recorded.

6.7 A system for capturing participants feedback and evaluation of the training provided should be in place. Information from feedback / evaluation should be shared with managers.

6.8 Full records of all training provided must be kept including:
   - Printed names and signatures of trainee and trainers
   - Employees job title and place of work
   - Date and venue of training
   - Level of participation for all components of the training session ie, full/observed only
   - Content of training session and title / level
   - Declaration of health status.
   - Detailed lesson plan for each training session.

7. What the Standard Elements of training should include

7.1 This training programme is broken down into modules to allow for flexibility in content and delivery. It specifies the minimum standards required.

7.2 Employing organisations participating in this passport scheme must ensure that their training courses meet the aims and objectives specified within each training module as a minimum.

Module A  Induction & Awareness raising
Module B  Theory of Personal Safety and De-escalation
Module C  Breakaway
(Module D  Physical Intervention – under development)
8. **The importance of audit and review**

8.1 Managers and employees need to acknowledge the importance of monitoring practice in the workplace.

8.2 A robust monitoring system to support the implementation of audit and review of practice associated with the management of violence and aggression must be put in place.

8.3 Incidents associated with violence and aggression must be thoroughly reviewed and appropriate action taken to reduce the likelihood of future incidents as far as reasonably practical.

8.4 A mechanism to support post incident debriefing must be put in place to ensure the timely review of events associated with the incident and ensure lessons learnt are appropriately shared.
PART 2: VIOLENCE AND AGGRESSION TRAINING
AIMS AND OBJECTIVES

1. The aim of the training is to provide employees with the varying degrees of information/skills that they require to protect themselves and others from the risk of violence and aggression.

2. NHS organisations participating in the Passport Scheme must ensure, as a minimum, that their training courses meet the aims and objectives specified within each training module.

3. The training programme is broken down into modular sections to allow for flexibility in its delivery. The modules cover the following topics:

- Module A – Induction & Awareness Raising
- Module B – Theory of Personal Safety and De-escalation
- Module C – Breakaway

Module A – Induction and Awareness Raising

The suggested time for this session is one hour.

Introduction

This particular module will provide participants with a general introduction to the subject of violence and aggression. It will provide a basic overview of the importance of managing violence and aggression in the workplace. It will also reflect upon the prevalence of violence and aggression within society and its relevance to the workplace. This will be supported through the provision of clear definitions for violence and aggression. Local policy and procedures will also be introduced.

Aims

- To introduce trainer (self)
- To raise awareness of employers and employees rights and responsibilities.
- To introduce key issues in the management of violence and aggression.
Objectives - at the end of the session the trainee should be able to:
- Define the terms ‘violence and aggression’.
- Describe where you will locate the local policy and procedure for management of violence and aggression.
- Demonstrate an awareness of the staff support mechanisms available within the organisation and how to access this service.
- Demonstrate an understanding of the importance of reporting incidents and be able to describe the process for reporting such incidents.

Identification of the Problem of Violence and Aggression

Aims
- To raise awareness of the changing culture of violence and aggression in society in relation to NHS/organisation employees.
- To raise awareness of the duty of care owed by the employer and employee.

Objectives
- Outline factors contributing to the changing culture within the organisation.
- State the responsibilities of the employer.
- Demonstrate knowledge of their responsibilities as employees.
- Define the concept of risk assessment.

Define Violence and Aggression

Aim
- To raise awareness of the meaning of the terms violence and aggression.

Objective
- Demonstrate an awareness of the different types of violence and aggression.
Local Policy and Procedures

- **Aims**
  - To raise awareness of the existence of the local policy and procedure and their location.
  - To raise awareness of staff support systems available within the organisation.

- **Objectives**
  - Describe how they would locate the policy and procedure within their workplace.
  - Demonstrate an awareness of the staff support mechanisms available within the organisation and how to access this service.

Reporting Incidents

- **Aim**
  - To raise awareness of the importance of reporting incidents of violence and aggression.

- **Objective**
  - Demonstrate an understanding of the importance of the incident reporting system and its relevance to the organisation.

Module B – Theory of Personal Safety and De-escalation

The suggested time for this session is 3 hours.

Introduction

This particular module will provide participants with greater awareness of issues associated with the theory of personal safety and de-escalation. It builds upon the introductory module and must be undertaken prior to any other additional modules. Emphasis is placed upon the importance of de-escalation and the steps which can be taken to prevent incidents of violence and aggression occurring in the first place. The module is intended to equip participants with the skills to recognise and de-escalate potential violent incidents and will include issues associated with customer care and diversity.
Personal Safety and De-escalation

Aims
- To raise awareness of the terms violence and aggression.
- To increase awareness of personal safety.
- To increase awareness of the environment and the risks that it can present.
- To increase recognition of trigger factors which can lead to violent and/or aggressive behaviour.
- To have an awareness of communication skills which can assist in diffusing violent and aggressive situations.
- To emphasise the importance of relevant health and safety legislation.
- To increase awareness of legal and ethical issues.
- To increase awareness of cultural and gender issues.
- To increase awareness of policies and procedures on the management of violence and aggression in the workplace.
- To increase awareness of the post incident support debriefing.

Objectives - at the end of the session the trainee should be able to:
- Define the terms ‘violence and aggression’.
- Describe the factors which could influence and affect your personal safety and environment.
- Identify trigger factors which can lead to a violent and/or aggressive incident.
- Identify communication skills which can de-escalate a potentially aggressive and/or violent situation.
- Discuss legal and ethical issues associated with the management of violence and aggression.
- Discuss cultural and gender issues associated with the management of violence and aggression.
- State employer and employee responsibilities with regard to relevant health and safety legislation.
- Demonstrate an understanding of the organisation’s policies and procedures on the management of violence and aggression.
- Demonstrate an understanding of staff support systems available.
Identification of Personal Safety Factors

Aims
- To raise awareness of the terms violence and aggression.
- To increase awareness of personal safety.
- To increase awareness of the environment.

Objectives - at the end of the session the trainee should be able to:
- Define the terms violence and aggression.
- Describe the factors which could influence and affect their personal safety and environment.

Recognition of Communication Skills

Aim
- To increase awareness of the impact of verbal and non-verbal communication skills.

Objective – at the end of the session the trainees should be able to:
- List the different ways of communicating and demonstrate an understanding of the effect these may have upon others.

Recognition of Trigger Factors

Aims
- To increase recognition of trigger factors which can lead to violent and/or aggressive behaviour.
- To gain an understanding of how behaviour escalates into a violent and/or aggressive situation.

Objectives - the end of the session the trainees should be able to:
- Identify trigger factors which can lead to a violent and/or aggressive incident.
- Explain the assault cycle.
Legal and Ethical Issues

Aims

To emphasise the importance of relevant health and safety legislation.
To increase awareness of legal and ethical issues.
To raise awareness of the term ‘assault’.

Objectives - at the end of the session the trainees should be able to:

- Discuss legal and ethical issues associated with the management of violence and aggression.
- Define the term ‘assault’.

Local Policy and Procedures

Aim

To increase awareness of policies and procedures in the management of violence and aggression in the workplace.

Objective - at the end of the session the trainees should be able to:

- Demonstrate an understanding of the organisation’s policies and procedures in the management of violence and aggression.

Post Incident Support

Aim

To increase awareness of post incident support / debriefing.

Objective - at the end of the session the trainees should be able to:

- Demonstrate an understanding of staff support systems available.
Update/Refresher Training

Update/refresher training for employees should be prioritised based upon risk assessment. However, it is a requirement of the Passport Scheme that it takes place, for module B, as a minimum every 2 years. If an employee’s role changes or it is identified after initial training that they do not actually require this level of training then it is not necessary to update them to this level.

Module C – Breakaway

The suggested time for this module is 3 hours.

Introduction

This module will provide the participant with practical skills to enable them to breakaway from a situation of violence and aggression. Emphasis will be placed upon the importance of communication skills and management of personal safety throughout all breakaway techniques.

All participants must have received Module B before undertaking this module

Aims

- To provide practical techniques enabling breakaway from violent/aggressive situations.
- To reinforce the need to maintain communication which can assist in diffusing a violent/aggressive situation.
- To increase awareness of the environment and the risks it may present.
- To increase awareness of personal safety.
- To emphasise the importance of relevant health and safety legislation.
- To increase awareness of legal and ethical issues.
- To increase awareness of cultural and gender issues.
- To increase awareness of local reporting procedures.
- To increase awareness of the use of personal alarm systems.
- To raise awareness of the relevance of clinical risk assessment.
Objectives - at the end of the session the trainee should be able to:

- Describe the factors which could influence and affect your personal safety and environment.
- Explain communication skills which can assist in de-escalating a violent/aggressive situation.
- Demonstrate an understanding of local reporting policies and procedures.
- State employer and employee responsibilities with regard to relevant health and safety legislation.
- Discuss legal and ethical issues associated with the management of violence and aggression.
- Discuss cultural and gender issues associated with the management of violence and aggression.
- Demonstrate and practice the practical use of breakaway techniques, from an attack/grab, without causing harm to those involved. Situations will include:
  - Hair grabs
  - Wrist grabs
  - Clothes grabs
  - Strangle holds
- Describe situations which may require additional assistance.
- Describe circumstances when personal/alarm systems should be used.
- Explain how clinical risk assessment can help to reduce risk of assault.

Legal and Ethical Issues

Aims

- To emphasise the importance of relevant health and safety legislation.
- To increase awareness of legal and ethical issues.
- To raise awareness of the term ‘assault’.

Objectives - at the end of the session the trainees should be able to:

- Discuss legal and ethical issues associated with the management of violence and aggression.
- Define the term ‘assault’.
Hair grabs - Front and back

- **Aims**
  - To recognise when to disengage from a hair grab.
  - To safely disengage and withdraw from a hair grab without causing harm to those involved.

- **Objectives**
  - Demonstrate and practice the effective use of technique(s).
  - Describe when to utilise breakaway technique(s) (eg, elderly, adults etc.)

Clothes Grabs – Single and double grabs

- **Aim**
  - To recognise when to disengage from a clothes grab.
  - To safely disengage and withdraw from a clothes grab without causing harm to those involved.

- **Objectives**
  - Demonstrate effective use of technique(s).
  - Describe when to utilise breakaway technique(s) (eg, elderly, adults etc.)

Wrist Grabs – Single and double grabs

- **Aims**
  - To recognise when to disengage from a wrist grab.
  - To safely disengage and withdraw from a wrist grab without causing harm to those involved.

- **Objectives**
  - Demonstrate effective use of technique(s).
  - Describe when to utilise breakaway technique(s) (eg, elderly, adults etc.)
Strangle Holds – Front, side and back

- **Aims**
  - To recognise when to disengage from a strangle hold.
  - To safely disengage and withdraw from a strangle hold without causing harm to those involved.

- **Objective**
  - Demonstrate effective use of breakaway from strangle holds.

Policies, Procedures and Environmental Factors

- **Aims**
  - To increase awareness of the use of personal/alarm systems.
  - To emphasise the importance of environmental awareness.
  - To raise awareness of the relevance of clinical risk assessment.
  - To increase awareness of local health and safety policies and procedures.

- **Objectives**
  - Describe the benefits of personal/alarm systems.
  - Describe factors which could influence and affect personal safety.
  - Explain the relevance of clinical risk assessment within the management of potentially violent/aggressive situations.
  - Identify relevant health and safety policies and procedures.

Update/Refresher Training

Update/refresher training for employees should be prioritised based upon risk assessment. However, it is a requirement of the Passport Scheme that it takes place, for module C, as a *minimum* every 2 years. If an employees role changes or it is identified after initial training that they do not actually require this level of training then it is not necessary to update them in this particular module.
PART 3: RECORDS OF TRAINING

1. It is important that adequate records of training are maintained. Trusts and Local Health Boards participating in the scheme must review their methods of record keeping.

2. Standards for maintaining records must be recorded in the Trust or Local Health Boards policy. This must state how long the records will be kept for and who will maintain the records.

3. Each individual shall be given a copy of their own training record. This will transfer with them if they move to another employer.

4. Individual records of training are maintained in addition to lesson plans and teaching notes which will identify the actual material that was provided in any individual module.

5. An example of a record of attendance is provided together with an additional record of training for each module contained within the Passport Scheme.

6. Prior to any physical training taking place, an employee must complete a Health Questionnaire. Employees must also be aware that if they suffer any discomfort during training this must be reported immediately.
RECORD OF ATTENDANCE

COURSE TITLE ___________________________ MODULE _______ DATE __________

START TIME ___________ FINISH TIME____________ VENUE ____________________________

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TUTORS NAME: _______________ SIGNATURE: ___________ TITLE: ___________ DATE: ___________

TUTORS NAME: _______________ SIGNATURE: ___________ TITLE: ___________ DATE: ___________
OTHER INFORMATION
VIOLENCE AND AGGRESSION TRAINING QUESTIONNAIRE

During the training course you will be required to participate in physical activity. You will carry out a number of practical exercises. In order for the trainer to train you safely and provide guidance pertinent to you personally they need to know about any pre-existing condition which you may have. The information given will be treated in confidence.

If you knowingly give incorrect information the Trust/Local Health Board can bear no responsibility for any resultant pain or injury.

You are required therefore to tick in the box adjacent to any factor which could affect the way in which your training is provided and sign below.

1 I suffer from back, neck or shoulder pain or injury
2 I am receiving treatment for any condition which may affect my ability to engage in physical activity without pain or injury
3 I am pregnant
4 I have given birth in the last six months
5 I am breast feeding
6 None of the above applies

NAME: _____________________________ DoB: _____________

SIGNATURE: ________________________ DATE: ____________

- If you have answered ‘yes’ to any of the questions 1-5 the trainer may seek further information from you in confidence.
- If necessary advice will be sought from the Occupational Health Department.
- Should you suffer any discomfort or injury during the training you must report this to the trainer immediately.
INDIVIDUAL TRAINING RECORD – VIOLENCE AND AGGRESSION

Module A – Induction & Awareness Raising

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<td>Identification of the Problem of Violence and Aggression</td>
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<td>Define Violence and Aggression</td>
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<td>Local Policy and Procedures</td>
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<td>Reporting Incidents</td>
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I confirm that I have received instruction in the topics as indicated. I have also been given the opportunity to discuss relevant issues and ask questions.

I confirm that I have received all handouts.

Trainees Signature: ………………………………………………………

Trainers Name:…………………………….. Date:…………………………

Trainers Title: ………………………………………………………

Trainers Signature:……………………………………………………
Module B – Theory of Personal Safety and De-escalation

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<td>Legal and Ethical Issues</td>
<td></td>
</tr>
<tr>
<td>Local Policy and Procedures</td>
<td></td>
</tr>
<tr>
<td>Post Incident Support</td>
<td></td>
</tr>
</tbody>
</table>

I confirm that I have received training in the topics as indicated. I have also been given the opportunity to discuss relevant issues and ask questions.

I confirm that I have received all handouts

Trainees Signature: ……………………………………………………………

Trainers Name:………………………………………… Date: ……………

Trainers Title: ……………………………………………………………

Trainers Signature: ……………………………………………………………
Module C - Breakaway

NAME (PLEASE PRINT): ………………………………………………

<table>
<thead>
<tr>
<th>Topic</th>
<th>Discussed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td></td>
</tr>
<tr>
<td>Legal and Ethical Issues</td>
<td></td>
</tr>
<tr>
<td>Policies, Procedures and Environmental Factors</td>
<td></td>
</tr>
</tbody>
</table>

**Practical Skills**

<table>
<thead>
<tr>
<th>Situation /Techniques</th>
<th>Discussed</th>
<th>Demo</th>
<th>Practised</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hair grabs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• front</td>
<td></td>
<td></td>
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<tr>
<td>• back</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clothes Grabs</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• single</td>
<td></td>
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<tr>
<td>• double</td>
<td></td>
<td></td>
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<tr>
<td>Wrist Grabs</td>
<td></td>
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</tr>
<tr>
<td>• single</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• double grabs</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Strangle Holds</td>
<td></td>
<td></td>
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<tr>
<td>• front</td>
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<td>• side</td>
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<tr>
<td>• back</td>
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</tr>
</tbody>
</table>

I confirm that I have received training in the topics and techniques as indicated. I have also been given the opportunity to discuss relevant issues and ask questions.

I confirm that I have received all handouts

Trainees Signature: ………………………………………………………………

Trainers Name: ………………………. Date: ……………………

Trainers Title: ………………………………………………………………

Trainers Signature: ………………………………………………………………
PART 4 : VIOLENCE AND AGGRESSION RISK ASSESSMENT

1. The Management of Health and Safety at Work Regulations 1999 requires employers to assess the risks their staff face through the work they carry out. This includes the risk of violence and aggression. The assessment should identify the measures needed to either eliminate the risks or, if this is not reasonably practicable, adequately control them.

2. The Regulations do not specify which measures should be introduced to control the risk. It is for the employer to satisfy themselves that the measures they have taken are adequate. In doing so the Trust or Local Health Board must consider the good practice of other employers managing similar issues.

3. A Violence and Aggression Risk Assessment should be documented for any task/activity which presents a significant risk. The form contained within this pack is designed for the assessment of generic activities and tasks. It is not intended to be used to assess risks relating to a specific patient. A separate Patient Risk Assessment should be undertaken if an individual is presenting a risk. There are a number of these assessments already in existence e.g., FACE (Functional Analysis of Care Environments) Risk Assessment which is used in some mental health settings. The Steering Group intends to publish good practice guidelines for undertaking individual patient risk assessments although it does not intend to produce a specific form.

4. Where individual Patient Risk Assessments are undertaken they should be reviewed and updated when necessary. The significant findings should be communicated to all relevant departments within the Organisation and other agencies. However, it is important to ensure that the Data Protection Act 1998 is not contravened and that information is shared on a ‘need to know’ basis.

5. In addition to formal documented risk assessments employees must conduct a Personal Risk Assessment before they perform a task/activity which may present a risk of violence and aggression. This assessment should examine the risk to themselves and others who may be affected by the activity. If necessary they must communicate their findings to others.
GUIDANCE NOTES ON COMPLETING THE ALL WALES NHS VIOLENCE AND AGGRESSION RISK ASSESSMENT FORM

The following notes are designed to allow you to carry out a suitable and sufficient assessment of the risk of violence and aggression in your Ward/Department/working environment. The form is divided into 7 main sections. The aim has been to make the areas to be assessed as clear as possible. It is not possible to cover all eventualities and those completing the form must not feel that they cannot record any other relevant details. Where necessary continuation sheets can be used.

**Section A – Administration Details**

This section is designed to identify the location where the assessment is being conducted.

The risk assessment should be undertaken in consultation with employees and reviewed at least annually or after an incident has occurred. If a major change is required as part of a review a new form must be completed. If the circumstances remain largely the same then there is a section to record that a review has been undertaken.

**Section B – Task or Activity**

Write down the tasks or activities which could lead to a risk of violence and aggression. Generic terms can be used such as interviewing/assessment of patients, undertaking receptionist duties, security patrols, visiting patients in the community etc. Where it is felt that there is a specific activity which presents an elevated risk this may need to be documented separately eg, providing homeless outreach services.

Specify the personnel that may be involved in the task or activity. Remember to consider students and other personnel who may be similarly at risk eg, medical staff, social workers undertaking joint assessments, porters, domestics etc.
Section C – Assessment of Risk

This section is designed to identify the likelihood of the risk of violence to employees based on the various hazards that employees may be exposed to in undertaking their duties. The section should be completed by answering all of the relevant questions. Once this has been done the answers should be reviewed and a decision of the degree of perceived/actual risk made.

It is important to consult all those who may be involved in the activity/task when undertaking a risk assessment. Perception of risk may vary from individual to individual. Also employees may have been involved in incidents which they have not previously reported or shared with their colleagues.

If after completing Point 1 it is felt that there is no perceived or actual risk the form need not be completed any further.

Points 5 and 6 questions whether incidents of violence and aggression are more likely to occur on specific days or times of day. This may be important when planning control measures eg, it may be more important to have additional staff when the pubs are closing, or patients may be more likely to be aggressive during periods when there is limited activity or stimulation.

Point 14 – staff may be particularly vulnerable when they are working alone or in isolation from others. It is important to ensure that when employees are required to work alone there are adequate procedures in place. Further guidance on the risks from ‘lone working’ together with good practice can be found in Part 6 of the Passport Scheme.

Point 15 - A great deal of emphasis can be placed on the provision of alarm systems. However, they do not control or reduce the risk of violence and aggression but merely serve to allow the person being exposed to call for assistance. When installing alarm systems appropriate arrangements must be made for management of the system and to ensure that there is an effective response to any incident.
Point 16 – Training – The All Wales NHS Violence and Aggression Training Passport and Information Scheme sets out the minimum standards for training in violence and aggression (refer to Part 2 of the Passport Scheme). The training is designed to allow employees to attend those modules appropriate for the risk to which they are exposed. A Training Needs Analysis should have been undertaken to identify the level of training that is required. However, training requirements may change as a result of a Risk Assessment and the introduction of additional control measures. Section 16 should be amended if this is found to be the case.

Point 17 – Contingency Plans that are put into place must be appropriate and managed. It is no use relying on a contingency plan which requires unrealistic arrangements to be in place. Also it is necessary to ensure that plans are robust and allow for such operational issues as annual leave and sickness. **Staff must be aware of circumstances when they should dial 999 or other emergency numbers.**

Point 18 – This section relates to community and home visits. It is appropriate to record if staff are required to visit known trouble spots. It is also good practice to ensure that individual assessments are undertaken of premises visited. Some Trusts and Local Authorities already have systems where the person making the referral has an obligation to identify any known risks. Such systems are commendable and should be extended across the health and social care sector.

**Section D – Current Control Measures**

This section is where any existing control measures/precautions are listed. Many of these control measures will have been highlighted in Section C. These can be summarised and cross referenced where appropriate. A continuation sheet can be used if necessary.
Section E – Initial Risk Rating Figure

In order to prioritise actions, it is necessary to evaluate the level of risk presented by the hazards identified. This is done using a simple rating system and a basic multiplication. Further guidance is given in the Risk Matrix Section.

Section F – Additional Risk Control Measures Required

Where the level of risk is considered to be unacceptable this part of the form is used to determine additional risk control measures.

When considering actions to be taken a hierarchy of risk control measures should be considered in the following order;

- Elimination or removal of the risk
- Substitution with a less risky option
- Enclosure or segregation of the risk
- Prevention of access of/to the risk
- Organising work to reduce exposure to the risk
- Safe systems of work/safe operating procedures

Consideration should also be given to staff training requirements, including those arising from implementation of the control measures.

There will be occasions when the additional control measures required may take some time to implement. The request for these controls should form part of the Action Plan to be agreed with the manager. The new risk rating figure will quantify the projected reduction in risk.

Section G – Action Plan Agreed with Manager

The Action Plan is documented confirmation that the additional risk control measures have been identified and agreed with the manager. This should specify the expected completion date and confirm when controls have been implemented. A final/residual risk rating figure should then be calculated: this may be different to the risk rating detailed in Section F if some of the recommendations cannot be actioned.
RISK MATRIX

Note: You must assess each risk against the likelihood of an incident occurring and should it happen the severity of the consequences.

Review of Risk Assessments - you must review your risk assessments in the following three circumstances:
- in accordance with the specified review period and/or
- as a result of change, and/or
- following an incident

LIKELIHOOD:
Taking into account the controls in place and their adequacy, how likely is it that such an incident could occur? Apply a score according to the following scale:

<table>
<thead>
<tr>
<th>Level</th>
<th>Descriptor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Almost Certain</td>
<td>Likely to occur on many occasions, a persistent issue</td>
</tr>
<tr>
<td>4</td>
<td>Likely</td>
<td>Will probably occur but it is not a persistent issue</td>
</tr>
<tr>
<td>3</td>
<td>Possible</td>
<td>May occur occasionally</td>
</tr>
<tr>
<td>2</td>
<td>Unlikely</td>
<td>Do not expect it to happen but it is possible</td>
</tr>
<tr>
<td>1</td>
<td>Rare</td>
<td>Can’t believe that this will ever happen</td>
</tr>
</tbody>
</table>

SEVERITY:
Taking into account the controls in place and their adequacy, how severe would the consequences be of such an incident? Apply a score according to the following scale:

<table>
<thead>
<tr>
<th>Level</th>
<th>Descriptor</th>
<th>Actual or Potential Impact on Individual(s)</th>
<th>Actual or Potential Impact on Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Catastrophic</td>
<td>DEATH</td>
<td>National adverse publicity. WAG Investigation. Litigation expected/certain.</td>
</tr>
<tr>
<td>4</td>
<td>Major</td>
<td>PERMANENT INJURY: eg, RIDDOR reportable injury/ Ill health retirement/redeployment</td>
<td>RIDDOR reportable Long-term sickness. Litigation expected/certain.</td>
</tr>
<tr>
<td>3</td>
<td>Moderate</td>
<td>SEMI-PERMANENT INJURY/DAMAGE eg, injury that takes up to one year to resolve or requires Occupational Health involvement/rehabilitation</td>
<td>Litigation possible but not certain. High potential for complaint.</td>
</tr>
<tr>
<td>2</td>
<td>Minor</td>
<td>SHORT-TERM INJURY/DAMAGE eg, injury that has been resolved within one month Short-term sickness.</td>
<td>Minimal risk to organisation. Litigation unlikely. Complaint possible.</td>
</tr>
<tr>
<td>1</td>
<td>Insignificant</td>
<td>NO INJURY OR ADVERSE OUTCOME</td>
<td>No risk at all to organisation. Unlikely to cause complaint. Litigation risk remote.</td>
</tr>
</tbody>
</table>
## RISK SCORE/ACTION TO BE TAKEN:

<table>
<thead>
<tr>
<th>LIKELIHOOD</th>
<th>SEVERITY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 Insignificant</td>
</tr>
<tr>
<td>1 - Rare</td>
<td>1</td>
</tr>
<tr>
<td>2 - Unlikely</td>
<td>2</td>
</tr>
<tr>
<td>3 - Possible</td>
<td>3</td>
</tr>
<tr>
<td>4 - Likely</td>
<td>4</td>
</tr>
<tr>
<td>5 - Almost certain</td>
<td>5</td>
</tr>
</tbody>
</table>
ALL WALES NHS VIOLENCE & AGGRESSION
RISK ASSESSMENT FORM

SECTION A: Administration Details

| Primary Location (eg, Hospital, Health Centre, etc.): | …………………………………… |
| Secondary Location (eg, Ward, Dept. etc.): | …………………………………… |
| Exact Location (eg, Interview Room, Reception, etc.): | …………………………………… |

| Name of Assessor: | …………………………………… |
| Designation: | …………………………………… |
| Date of Initial Assessment: | …………………………………… |
| Date of Review: | …………………………………… |
| Name/Designation of Assessor: | …………………………………… |
| Date of Review: | …………………………………… |
| Name/Designation of Assessor: | …………………………………… |

SECTION B: Task or Activity

Description of task or activity which could lead to a risk of violence and aggression:

Personnel involved (eg, carer, nurse, health visitor, community staff, security staff, contractor, off site worker, etc.)

This risk assessment should be conducted in consultation with employees and reviewed at least annually or after an incident has occurred. If a major change is required as part of a review a new form must be completed.
### SECTION C: Assessment of Risk

In each of the sections, tick the appropriate box (Yes, No, N/A)

<table>
<thead>
<tr>
<th>1a Is there any historical evidence of verbal or physical aggression to staff?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal abuse (with intent/directed at staff)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbal abuse (abusive remarks not directed at staff)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Punch/strike/slap</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wounding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kicking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scratching</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grabbing by patient (please specify areas grabbed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hair pulling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stalking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victimisation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intimidation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Threat with/use of weapon (eg, knives, needles, walking sticks, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please specify:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harrassment (racial, sexual, bullying)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Offensive messages</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rape</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Robbery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please specify:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1b Is it perceived that there could be a risk of any of the above?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please specify:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If there is no perceived or known risk of verbal or physical aggression there is no need to continue with this assessment.
2 How often do violent incidents occur?
- Never
- Every few months
- Once a month
- Several times a month
- Once a week
- Several times a week
- Once a day
- Several times a day

3a If hurt or wounded as a result of an attack, has it lead to:
- Yes
- No
  - Bruising/swelling
  - Dislocation
  - Fracture
  - Cuts
  - Multiple injuries
  - Sprains
  - Stress
  - Other

3b Is it perceived that an incident could lead to any of the above?
- Please specify:
  - …………………………………………………………………………………………
  - …………………………………………………………………………………………
  - …………………………………………………………………………………………

4 Following attacks or incidents of aggression, has this led to time off work?
- Yes
- No
  - A few hours
  - Days
  - Weeks
  - Months
<table>
<thead>
<tr>
<th>5 When are violent incidents more likely to occur (please tick)?</th>
<th>6 On what day of the week?</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 am - 5 pm</td>
<td>Sunday</td>
</tr>
<tr>
<td>5 pm - 10 pm</td>
<td>Monday</td>
</tr>
<tr>
<td>10 pm - 2 am</td>
<td>Tuesday</td>
</tr>
<tr>
<td>2 am - 8 am</td>
<td>Wednesday</td>
</tr>
<tr>
<td>At any time</td>
<td>Thursday</td>
</tr>
<tr>
<td></td>
<td>Friday</td>
</tr>
<tr>
<td></td>
<td>Saturday</td>
</tr>
<tr>
<td></td>
<td>Any day</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7 Is the workplace overcrowded?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>All the time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td></td>
<td></td>
</tr>
<tr>
<td>During specific times</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please specify:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8 Are the following adequate?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lighting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temperature</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ventilation (fresh air/smells)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Décor / colour schemes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housekeeping</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seating for patients/visitors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please specify:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are the following readily available for patients/visitors?</td>
<td>Yes</td>
</tr>
<tr>
<td>---</td>
<td>----------------------------------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td></td>
<td>Public telephones</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Toilets</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Light refreshments</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Information service</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Up-to-date magazines</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Children’s play area</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Music</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>TV/Videos</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Internal environmental issues</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Are there excessive noises which could cause distraction?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Are there isolated areas such as treatment rooms, offices, etc?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Are the rooms laid out in such a way as to allow staff to exit in an emergency?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Could the aggressor be situated between the employee and the door?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Are there designated waiting areas?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Are these adequately supervised?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Are there corridors /areas where aggressors could hide / congregate?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Is there adequate signage displaying the Organisations Zero Tolerance stance?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Are staff protected by additional security measures where required eg screens, security locks, intercoms, internal CCTV?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Is money / valuables kept in the work area?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Question</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
<td>-----</td>
<td></td>
</tr>
<tr>
<td><strong>11 Are there potentially dangerous fixtures and fittings, eg,</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ash trays</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tables</td>
<td></td>
<td></td>
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<tr>
<td>Waste bin</td>
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<tr>
<td>Seats</td>
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<tr>
<td>Sharp corners</td>
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<tr>
<td>Surgical/medical equipment</td>
<td></td>
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<tr>
<td>Office equipment</td>
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<tr>
<td>Other</td>
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<tr>
<td>Please specify:</td>
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<tr>
<td>Are there any times when tasks are undertaken alone?</td>
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<td>If yes, please specify:</td>
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<tr>
<td>Are there any procedures in place to help ensure safety?</td>
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<tr>
<td>If yes, please specify:</td>
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</tbody>
</table>
### 15 Are there alarm systems in place by which you can summon help?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
</table>

If yes, please state type of system:  
………………………………………………………………..  

Are alarms fitted in rooms used for interviewing potentially aggressive/violent individuals?  
………………………………………………………………..  

Are these alarms accessible to staff?  
………………………………………………………………..  

Are the alarms easy to activate?  
………………………………………………………………..  

Are staff trained in their use?  
………………………………………………………………..  

Do others know how to respond if the alarm is raised?  
………………………………………………………………..  

Are there documented procedures in place for ensuring this?  
………………………………………………………………..  

Can the alarm be heard in all areas of the ward/department?  
………………………………………………………………..  

### 16 Have staff attended appropriate training in accordance with All Wales NHS Violence and Aggression Training Passport and Organisations Policy?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Level of training and number of staff identified in Training Needs Analysis as requiring each level of training:-  

*Module A – Induction & Awareness Raising.*  
……………………………………  

*Module B - Theory of Personal Safety and De-escalation*  
……………………………………  

*Module C - Breakaway*  
……………………………………  

*Module D - Physical Intervention*  
……………………………………  

Number of staff who have attended training:-  

*Module A – Induction & Awareness Raising.*  
……………………………………  

*Module B - Theory of Personal Safety and De-escalation*  
……………………………………  

*Module C - Breakaway*  
……………………………………  

*Module D - Physical Intervention*  
……………………………………  

What procedures are in place to ensure that all staff (including medical staff) have information and access to violence and aggression training?

………………………………………………………………..  

………………………………………………………………..  

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<table>
<thead>
<tr>
<th>17</th>
<th>Is there a contingency plan if violence is threatened or breaks out toward:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patients</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Visitors</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td></td>
<td>Staff</td>
<td>☐</td>
<td>☐</td>
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<td></td>
<td>Please specify arrangements:</td>
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<td>.................................................................................................</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Are staffing levels adequate to ensure that contingency plans can be followed?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>18</th>
<th>Home / community visits</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Are home / community visits essential?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td></td>
<td>Is any information sought highlighting previous / known risks associated with the patient and / premises / or locality?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Where joint agency working takes place are there protocols for sharing information regarding known risks of violence and aggression?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Is joint agency visiting considered where appropriate?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Are individual risk assessments undertaken?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td></td>
<td>Is there a tracking system to ensure safety prior to, during, and at the end of a visit (eg, buddy systems, lone working procedure).</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Are mobile phones provided together with training in their use?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td></td>
<td>Are personal safety alarms provided and information given on their use?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>19</th>
<th>Policy / Procedures</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Is the Organisation's Policy easily accessible to all staff?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Is there an Information Leaflet available to all staff?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Do you have a departmental Policy / Procedure?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
SECTION D: Current Risk Control Measures (see Section C)

Control measures currently in use:

SECTION E: Initial Risk Rating Figure

Initial Risk Rating Figure (to calculate see Risk Matrix):

Probable Likelihood Rating \[\square\] \text{ x Potential Severity Rating} \[\square\]

\[= \text{Risk Rating Figure}\] \[\square\]
### SECTION F: Additional Risk Control Measures Required

Additional control measures to be recorded within this box. The request for these measures should be subjected to a risk priority along with other risks within the location and will form part of a prioritised risk register.

<table>
<thead>
<tr>
<th>No.</th>
<th>Risk Reduction Measures / Further Action</th>
</tr>
</thead>
</table>

If the above control measures are implemented, calculate the **New Risk Rating Figure:**

Probable Likelihood Rating \[ \times \] Potential Severity Rating \[ = \text{Risk Rating Figure:} \]
Once the above action plan has been implemented, calculate the **Final/Residual** Risk Rating Figure:

\[
\text{Probable Likelihood Rating} \times \text{Potential Severity Rating} = \text{Risk Rating Figure}
\]

**SECTION G: Action Plan Agreed with Manager**

<table>
<thead>
<tr>
<th>No.</th>
<th>Action Plan</th>
<th>Responsible Person</th>
<th>Projected Completion Date</th>
<th>Date Completed / Signature</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

**Additional Comments**
PART 5: GUIDANCE FOR PROTECTING NHS EMPLOYEES FROM VIOLENCE AND AGGRESSION

1. Organisations are required under health and safety legislation to take all reasonably practicable measures to protect their employees from the risks of violence and aggression.

2. Patients, visitors and other persons coming into contact with NHS employees must appreciate that it is not acceptable for them to act in a violent or aggressive way towards them. It is therefore necessary for the organisation to have suitable arrangements for dealing with such individuals.

3. The guidance contained within this section attempts to provide NHS organisations with a number of different approaches. These range from the clinical team discussing their concerns with the individual involved to exclusion from the organisations' premises for all but emergency treatment.

4. The guidance has been developed with the assistance of the South Wales Police and Morgan Cole solicitors.

NOTE: Where roles and job titles are used throughout this document the Trust/Local Health Board will have to replace these with appropriate roles to suit the organisation.
GUIDANCE FOR
PROTECTING NHS EMPLOYEES FROM
VIOLENCE AND AGGRESSION

Date: September 2004

Author: All Wales NHS Steering Group for the Management of Violence and Aggression
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Application 64
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Training and Support 74

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Appendix 3 - Letter to General Practitioner 79
Appendix 4 - Letter to Patient 80
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Appendix 6 - Exclusion Letter to Patient 84
1. **Introduction**

1.1 There has been a dramatic increase in recent years in the level of violence and aggression faced by staff, visitors and patients. Incidents have included significant injury to staff, damage to vital equipment and extreme verbal abuse and threats.

1.2 There is a widespread recognition of the need to tackle such behaviour effectively. The fear of violence can seriously affect morale and the ability to retain and recruit staff.

1.3 This document is designed to improve the organisations ability to tackle violent and aggressive incidents. The aim is to detail the behaviours that are unacceptable and the range of remedies available in the face of such behaviour. This includes a mechanism whereby in extreme cases patients can be excluded from the organisation’s premises.

1.4 Following a violent or aggressive event, managers and clinicians at a senior level should support staff towards seeking a solution which will enable medical treatment to continue and consideration of the alternative solutions which may be available.

1.5 The NHS has a legal obligation to identify the risk of violence and aggression and develop appropriate prevention strategies. The Zero Tolerance campaign recognised that ‘This can lead to dilemmas for clinicians and managers in meeting their obligations to patient care’.

2. **Policy Statement**

2.1 NHS organisations have a duty to provide a safe and secure environment for patients, staff and visitors. Violent or abusive behaviour will not be tolerated and decisive action will be taken to protect staff, patients and visitors. Guidance within this document has been developed utilising legal advice received.

2.2 Continuous difficult and challenging behaviour or hostility by a patient, relative or member of the public can result in staff being unable to provide the necessary care in the best interest of the patient. This behaviour is not acceptable and this document outlines the appropriate management of these incidents.
2.3 Any person behaving in an unlawful manner will be reported to the police and the organisation will seek the application of the maximum penalties available in law (having given due regard to the sections detailed below regarding ‘capacity’). The organisation will, where appropriate, seek to prosecute all perpetrators of crime on or against the organisations staff, property or assets. The appropriate manager or senior member of staff will contact the police in the event of unlawful behaviour. They will also liaise with the Security Manager* and legal department when seeking to prosecute, or support individual employees in the prosecution of perpetrators of a crime.

3. **Scope**

3.1 The scope of this document relates to all members of the public, patients, contractors and visitors. All employees, including those on honorary contracts, those working for other employers but on the organisations premises, and volunteers undertaking duties on behalf of the organisation have a duty in the implementation of this guidance.

3.2 Suitable consideration should be given to patients who are not competent to take responsibility for their actions because of either their age or because in the clinical judgement of relevant clinicians they do not have mental capacity.

3.3 Whilst much of this document will be relevant to the Ambulance Service, specific arrangements will need to be developed which recognise the unique circumstances faced by Ambulance Service staff.

4. **Aim**

4.1 The aim of this document is to provide mechanisms for dealing with the varying level of violence.

4.2 This guidance is introduced in the context of ensuring that all employees are able to provide care to patients within a safe environment and must be applied effectively in all appropriate situations.
5. **Definitions**

Definitions used throughout this document are as follows:-

5.1 **Violence**

Any incident where staff are abused, threatened or assaulted in circumstances relating to their work, involving explicit or implicit challenges to their safety, well-being or health. This can incorporate some behaviours identified in harassment and bullying, for example verbal violence.

5.2 **Persistent unacceptable behaviour**

Behaviour which is deemed unacceptable within one admission and/or over a number of separate attendances within a period of time.

5.3 **Unacceptable standards of behaviour**

The following are examples of behaviours that are not acceptable on NHS premises, or locations where patients receive treatment:

- Excessive noise eg, loud or intrusive conversation, shouting or uncontrollable misbehaviour
- Threatening or abusive language involving excessive swearing or offensive remarks
- Derogatory racial or sexual remarks
- Wilful damage to the organisations property
- Malicious allegations relating to members of staff, other patients or visitors
- Inappropriate behaviour as a result of alcohol or misuse of drugs
- Threats or threatening behaviour
- Violence, perceived acts of violence or threats of violence
- Any explicit or implicit challenge to the safety, well being or health of any member of staff or patient.
5.4 **Formal Patient Undertaking**

A Formal Patient Undertaking is a process where the patients’ rights and responsibilities are brought to their attention. The patient is asked to confirm that they understand that failing to comply with these responsibilities could result in the withdrawal of care except for emergency treatment.

5.5 **Adult**

Person aged over 18.

5.6 **Child and Young Person**

Person age under 16.

NB. those aged between 16 and 18 can be normally classed as a person with capacity (ie, an adult) unless there are circumstances which leads staff to consider otherwise.

5.7 **Capacity**

An individual is presumed to have capacity for the purpose of this guidance unless he or she:

- is unable to take in and retain the information material to the circumstances especially as to the likely consequences of their behaviour in the effect it may have on them having or not having the treatment; or
- is unable to weigh the information in the balance as part of a process of arriving at the decision.

Mental disorder does not necessarily mean that a patient does not have the capacity to refuse consent. Capacity is variable in people with mental disorder and should be assessed in relation to the particular patient, at a particular time, as regards a particular action/episode of violence or aggression.

6. **Application**

6.1 The communication of a patient’s past behaviour both within the organisation and to any other relevant agency is fundamental in minimising the risk of violence.
6.2 A ‘marker’ could be placed on a patient’s medical records to alert staff to the potential risk of violence and aggression. The Data Protection Act 1998 regulates the holding and processing of personal data, which is held either on computer or in a manual form.

6.3 Under the Act individuals are given legally enforceable rights. Organisations must comply with data protection principles, which together form a framework for proper handling of personal data. Advice on this requirement has been given by the Information Commissioner to the extent that:

- The processing of information is justified if necessary “for the compliance with any legal obligation to which the data controller is subject, other than an obligation imposed by contract”.

- The duties imposed on the employers under Section 2 and 3 of the Health and Safety at Work etc Act 1974 would be considered relevant to meet this requirement.

6.4 The Data Protection Act also imposes a duty with regard to sensitive personal data. ‘Violent markers’ will not usually be considered as sensitive personal data. With the possible exceptions of markers which indicate that the patient suffers from a mental illness causing violent behaviour or that of a criminal conviction or suspicion of criminal activity.

6.5 In addition it includes the requirements that:

- The patient should be informed that their details have been flagged to indicate that they are potentially violent.
- A decision should be made by a senior manager based on nature of the incident(s).
- Data should be held for an agreed period.
- Data should only be seen by those who would be at risk.
- On request from the individual the record including the ‘marker’ would have to be revealed and would therefore need to be justifiable.
6.6 Advice is also given on the ability to pass information to other agencies such as the Ambulance Service. In some cases other agencies who will have contact with a potentially violent individual should be informed that a warning ‘marker’ has been added to an individual’s file and details of the incident which led to this. It goes on to say that disclosure should be made on a strictly case-by-case basis.

6.7 The patients’ rights under the Articles of the Human Rights Act 1998 must be respected. Attention is drawn to the following rights:

- Article 2 ‘Right to Life’
- Article 3 ‘Prohibition of inhumane or degrading treatment’
- Article 8 ‘Right to Respect for Private and Family Life’
- Article 14 ‘Prohibition of Discrimination’

7. Remedies and Sanctions

7.1 Any action taken in response to violent or abusive behaviour should be carefully planned. It should take into account the clinical needs of the patients/service user, the right of all patients to be treated in a safe and caring environment and the duty towards employees.

7.2 The remedies which may be applied in this document will vary in relation to the perpetrator(s), eg,

- Remedies for visitors,
- Remedies against parents or those with parental responsibility/significant carers who behave in a continuously difficult and challenging way,
- Remedies against patients with capacity, and
- Remedies against those without capacity eg,
  a) Some mental health patients
  b) Some children and young people.
7.3 Actions implemented should be relevant to the circumstances. These include:

- Drawing the person’s attention to the fact that the behaviour is unacceptable
- Implementing a ‘Formal Patient Undertaking’
- Treatment of patients in the presence of increased security or police
- Formal Warning that such behaviour could lead to withdrawal of treatment (Yellow Card)
- Patient Exclusion - Withdrawal of Treatment except for emergency care
- Exclusion
- Legal proceedings.

7.4 Implementing remedies/sanctions against visitors.

The term ‘visitor’ includes a member of the general public or any one who is not a patient, member of staff or other persons employed by contract or service level agreement but excludes the parent of a child patient.

7.4.1 Visitors who display any of the behaviours listed previously should be asked to desist and offered the opportunity to explain their actions. The standards of behaviour expected of visitors should be clarified.

7.4.2 Continued failure to comply with the required standard of behaviour will result in the individual being asked to leave the premises by a senior member of staff. In the case of an ambulance the Crew who will inform the Control Officer. Such action will need to be undertaken with minimal risk and should not be attempted without appropriate support. Depending on the location and circumstances this would normally involve the Police or Security staff*.

7.4.3 The relevant senior manager may decide to continue to exclude any individual removed from the premises or restrict their visiting only to specific times and, if necessary, under escort from security staff*. The site manager, Personal Safety Adviser (or Health and Safety Department as relevant) and Security Manager* will be informed of any such exclusions and/or restrictions.
7.4.4 The visitor may request an immediate review of the exclusion by the appropriate service manager/deputy. They will be informed of any decision.

7.4.5 The visitor must be informed in writing of any extended exclusion or restriction placed on them and the proposed duration for review.

7.4.6 The exclusion of a visitor does not prevent them from attending the organisation for their own treatment.

7.4.7 The incident must be documented and reported as an incident in line with the organisation’s policy and procedure on the reporting of untoward incidents.

7.4.8 Any visitor behaving in an unlawful manner will be reported to the police and the organisation will seek the application of the maximum penalties available in law. The organisation will seek to prosecute all perpetrators of crime on or against the organisations staff, property or assets. The appropriate manager or senior member of staff will contact the police in the event of unlawful behaviour. They will also liaise with the Security Manager* and legal department when seeking to prosecute the perpetrators of a crime.

7.5 Implementing remedies/sanctions against those with parental responsibility.

7.5.1 It is not acceptable to the organisation for staff, other patients or visitors to be exposed to persons with parental responsibility who are violent, aggressive or behave in a continuously difficult and challenging manner. However, persons with parental responsibility have legal rights and responsibilities which need to be exercised in the best interest of the child. Remedies must ensure that the treatment of the child or young person can continue and decisions or consents relating to the continuation of the treatment can be made.
7.5.2 The staff should remain vigilant and attempt to prevent these situations developing. Senior staff should make every effort to support their junior colleagues in dealing with these difficult and complex problems. Incidents and observations should be appropriately recorded in the patients notes and on an incident form.

7.5.3 There must be a multidisciplinary approach towards the management of these children and families if safe, appropriate care is to be delivered.

7.5.4 Persons with parental responsibility who display any unacceptable standard of behaviour should be asked to desist and offered the opportunity to explain their actions. The standards of behaviour expected of them should be outlined. In any serious incident eg, involving violence causing injury or the threat of injury the police must be called.

7.5.5 The parent will be given the opportunity to immediately modify their behaviour and be offered an opportunity for ‘time out for cooling off’.

7.5.6 In the event of failure to modify their behaviour either before or after the 'cooling off' period, sanctions implemented should be proportionate to the actions of that person. Each individual situation needs careful assessment to ensure that the best interests of the child are met whilst ensuring staff safety.

7.5.7 Following violent behaviour, consideration should be given to making a referral to the Social Services Department as outlined in the All Wales Child Protection Procedures.

7.5.8 If violent or abusive parents insist on exercising their parental responsibility by attempting to ultimately remove their child from the healthcare setting an immediate referral should be made to Police and Social Services.

Full documentation of the incident must be made in a separate management file created to manage the situation and the incident reported as an incident, in accordance with the organisations reporting procedures.
7.5.9 Any parent or carer behaving in an unlawful manner will be reported to the police and the organisation will seek the application of the maximum penalties available in law. The organisation will seek to prosecute all perpetrators of crime on, or against its staff, property or assets.

7.6 Remedies and sanctions for adult patients with capacity (aged 18 or over).

7.6.1 Following any incident the immediate manager or departmental head (or their deputy) will ascertain that the patient has capacity from an appropriate clinician. The manager or departmental head will explain to the patient that his/her behaviour is unacceptable and explain the expected standards of behaviour.

7.6.2 If the behaviour continues, the responsible manager or clinician will give an informal warning about the possible consequences of any further repetition.

7.6.3 Failure to subsequently desist will result in an application of a ‘Patient Undertaking’ as a formal written warning of the consequences of such behaviour.

7.6.4 If a patient complies with the terms of the Patient Undertaking he/she can expect the following:

- That their clinical care will not be affected in any way.
- That a copy of the "Confirmation of Instituting a Patient Undertaking" will be filed in the Medical Directors Office* and a copy will also be kept in the patient’s notes. Use of the Patient Undertaking will be highlighted on Patient Information System. The patient will be told that the Confirmation will be recorded in these ways.
- That the organisations Security Manager*, Personal Safety Adviser/Health and Safety Department and the site managers will be informed.

7.6.5 Failure to comply with the Patient Undertaking will, at the request of the relevant senior manager and the Clinical Director (or their nominated deputies) result in exclusion from the organisation except in a medical emergency.
7.6.6 Such an exclusion will last for an agreed duration not exceeding one year. Subject to alternative care arrangements being made; the provision of such arrangements will be pursued with vigour by the relevant clinician. If an excluded individual presents at the organisation’s Accident and Emergency Department for emergency treatment, that individual will be treated and stabilised. Where possible, they would then be discharged immediately. However, they will be admitted if the medical condition of the patient is, in the clinical judgement of their lead clinician, so serious that admission is unavoidable the need for security staff attendance will be continually assessed by an appropriate member of staff. (See Appendix 1 for Procedure for Implementing a Patient Undertaking).

7.7 Community Care Services

7.7.1 This policy will apply to patients who require ongoing treatment within a community setting. The confirmation of Instituting a Patient Undertaking will be signed and held by the relevant Clinical Director, Medical Director, Security Manager* and Personal Safety Adviser/Health and Safety Department. Additionally, copies will be held at the relevant clinic for access by Out of Hours Nursing Staff/Medical Staff.

7.7.2 If an incident occurs within the community setting or a patient’s own home, the organisation’s Lone Worker Policy should be invoked and the incident reported to the relevant manager. If within a Primary Care setting eg, a clinic, the local procedure regarding violence and challenging behaviour should be followed. The principles outlined in this document should then, if appropriate, be invoked once the immediacy of the situation has been dealt with.

7.7.3 Any patient behaving unlawfully will be immediately reported to the police and the organisation will seek the application of the maximum penalties available in law. The organisation will seek police prosecution of perpetrators of crime on or against its staff, property or assets. Staff will be expected to co-operate in the provision of evidence.
7.8 Remedies and sanctions for a management of a child or young person.

7.8.1 Children under the age of 10 years are entirely exempt from criminal responsibility. Children between 10 and 14 years are also exempt unless it can be established that they can distinguish between right and wrong. Subject to this there may be certain circumstances where it is appropriate to seek advice and/or assistance from the police where a criminal offence may have been committed.

7.8.2 In addition to the procedure for dealing with adult patients, events involving a patient who is a child or young person should include support from Paediatric Social Workers and/or a member of the Child and Adolescent Mental Health Services if required.

7.8.3 There must be a multidisciplinary approach towards the management of these children and families if safe, appropriate care is to be delivered.

7.8.4 If not present at the time of the incident the parent/carer must be informed at the earliest opportunity.

7.8.5 The incident must be fully documented within the child’s/young person’s patient record and consideration given to making a child protection referral under the All Wales Child Protection Procedures.

7.8.6 Following a serious breach in acceptable behaviour or persistent unacceptable behaviour, a meeting between the child, parent/carer, ward manager/service manager/senior nurse and consultant co-ordinating care should be arranged. An advocate for the child should be invited to attend. This meeting should be arranged at the earliest possible time and include:

- Agreement of levels of acceptable behaviour and a behavioural management plan. Advice upon an appropriate behavioural management plan may be sought from Child and Adolescent Mental Health Service colleagues.
- Setting out a series of remedies that will be considered in the event of further non-compliance.
A letter detailing the Management Plan should be sent to the parent/carer within 24 hours. This should include the agreed visiting arrangements and acceptable behavioural management plan together with any alternative remedies which remain under consideration.

7.8.7 Any child or young person over the age of 10 years who behaves in an unlawful manner will be reported to the police and the organisation will seek the application of the maximum penalties available in law. The organisation will seek to prosecute all perpetrators of crime on or against its staff, property and assets.

7.9 Mental health patients

7.9.1 The abuse of employees by any individual is not condoned. Patients not detained under the Mental Health Act 1983 may be treated as any other adult with capacity.

7.9.2 Capacity is variable in people with mental disorder and should be assessed in relation to the particular patient, at the particular moment in time.

7.9.3 For patients detained under the Mental Health Act 1983 the Responsible Medical Officer will prepare a behavioural management plan and make recommendations for their care. In the event of non-compliance with the behavioural management plan the clinical condition and clinical needs of the patient will be taken into account when deciding on the appropriate further remedies. Discussion should include:

- The most appropriate physical environment and level of supervision required.
- Whether the patient should be subject to increased nursing observation.
- Whether the patient should be transferred to an alternative ward/hospital or team.
7.10 Further remedies relating to Children and Mental Health Patients.

These include:

- Consideration as to whether the treatment can be postponed and the patient discharged for a cooling off period or until more suitable arrangements for care can be made.
- Consideration as to whether the patient can be nursed in the community and be supervised as an outpatient. However, this should not then lead to a risk to community staff.
- Decision as to the circumstances when the police should be called in to advise or assist.

8. **Training and Support**

8.1 It is recognised that dealing with any situation in which individuals, whether child or adult, are violent, abusive or intimidating, can be very difficult. Appropriate training will be available to all staff who may become involved in the implementation of the policy.

8.2 Following an incident a de-briefing session will be offered to staff involved. This should be arranged by the line manager in conjunction with the Head of Department and/or appropriate Senior Nurse.

*NOTE: Where roles and job titles have been used throughout this document the Trust/Local Health Board will have to replace these with appropriate roles to suit the organisation.*
Appendix 1

Procedure for Implementing a Patient Undertaking

1. In the event of inappropriate behaviour by a patient and following careful review by the individuals clinical team (or the on call team out of hours), a Patient Undertaking can be used.

2. If the senior nurse on duty for the clinical area feels that a Patient Undertaking is appropriate, he/she should contact a suitable member of staff eg, the Directorate Manager/ Senior Nurse/Site Manager. (Organisation to insert appropriate person).

3. It is the responsibility of that suitable person (*see below) to do the following:

3.1 Take full details of the incident(s) and the staff member’s concerns, document them and decide whether a Patient Undertaking is required. Wherever possible, get witnesses to the event to sign the record as true and accurate.

3.2 Obtain confirmation as to the patient’s capacity.

3.3 If Patient Undertaking is required:

3.3.1 Inform and seek advice from the patient’s consultant or senior member of the medical team (on call team out of hours), or their GP if necessary.

3.3.2 Inform the patient of the staff’s concerns and explain the Procedure for Implementing a Patient Undertaking. Ensure that there is no confusion as to the standard of behaviour required or the possible consequences of failure to comply.

3.3.3 Complete the Patient Undertaking.

3.3.4 Ask the patient to sign the Patient Undertaking. If the patient refuses to sign, this should be documented, but explained to the patient that the document will be valid with or without the patient’s agreement.
3.3.5 Ensure that a suitable member of staff (any doctor or registered nurse) witness the explanation to the patient and signs the Patient Undertaking.

3.3.6 Give the patient a copy of the Patient Undertaking and of the policy itself.

3.3.7 Prepare a copy of the standard letter (Appendix 3), for issue to the patient’s GP. This letter should be signed and sent by the General Manager. A copy of the Policy should be attached.

3.3.8 Prepare a copy of the standard letter (Appendix 4), for issue to the patient. The General Manager should check the standard letter, the letter to the GP and that the Patient Undertaking procedure has been applied appropriately. The General Manager should then submit them to the Chief Executives’ Office for signature.

3.3.9 Copies of the application of the Patient Undertaking should be maintained by the relevant General Manager and Chief Executive. A copy must be kept in the patient’s notes and recorded on the Patient’s Information System, if appropriate.

3.3.10 Copies for information must be sent to the Trust/Local Health Board’s Secretary, Head of Security, Health and Safety Department and Medical Director.

3.3.11 The full process must be recorded in the patient’s medical and nursing documentation.

3.3.12 Explain to the patient that the Undertaking will be held centrally and in the patient’s records and will be flagged on the Patient Information System where available.

4. Examples of appropriate members of staff to initiate procedure are:

*Site Manager, General Manager, Chief Nurse, Clinical Director, Executive Director, Senior Nurse, Senior Clinician (registrar or above), Locality Manager (Primary Care), Out Of Hours – Nurse Practitioner.
Procedure for Issuing a Patient Undertaking Document:
Stage 1 of Procedure for Care of Patients with capacity who are Violent/Abusive

INCIDENT(S) OCCUR(S)

- Inform and seek advice from:
  - Patients consultant or senior medical team member
  - On call team out of hours
  - GP
- Ensure incident is documented in full and signed by staff member and any witnesses
- Record in patients medical and nursing notes and on incident form

Patient Undertaking indicated

PATIENT UNDERTAKING
- Inform patient of ward/community staffs concerns
- Fully explain the Patient Undertaking
- Reiterate standard of behaviour required
- Reiterate possible consequences of failure to comply
- Complete Patient Undertaking

Ongoing monitoring of situation

No action indicated

Prepare:
- Copy of GP letter (Appendix 3) plus policy
- Copy of patient letter (Appendix 4)
- Forward to General Manager

Chief Executive’s office to:
- Issue signed letter
- Copy procedure of care and letter to:
  - Trust/Local Health Board’s secretary
  - Originating General Manager
  - Head of Security
  - Health and Safety Department
  - Medical Director

General Manager to:
- Check procedure has been applied correctly
- Issue the letter to the GP
- Forward patient letter to the Chief Executive for signature

Ask patient to sign Patient Undertaking

Patient refuses

- Document refusal
- Explain document is valid with or without patient’s agreement

- Ensure doctor or registered nurse witnesses explanation and signs undertaking
- Inform Senior Manager
- Give patient copy of undertaking and policy
# RESPONSIBILITY AND RIGHTS - A PATIENT UNDERTAKING

<table>
<thead>
<tr>
<th>Your Rights</th>
<th>Your Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Trust/LHB and its employees owe to me, as a patient a duty of care and</td>
<td>I will not behave in any way, which can be considered to be</td>
</tr>
<tr>
<td>aim to provide services to meet my needs for healthcare and treatment at</td>
<td>violent or abusive.</td>
</tr>
<tr>
<td>all times.</td>
<td></td>
</tr>
<tr>
<td>The Trust/LHB and its employees aim to provide health services that are</td>
<td>Violence includes any incident where any members of staff are</td>
</tr>
<tr>
<td>sympathetic and responsive to my individual needs within the resources,</td>
<td>abused, threatened or assaulted in circumstances related to their</td>
</tr>
<tr>
<td>which the Trust/LHB has available.</td>
<td>work. An act of violence may involve an explicit challenge to the</td>
</tr>
<tr>
<td>The Trust/LHB and its employees want to deliver appropriate and effective</td>
<td>safety, well being or health of any member of staff or other</td>
</tr>
<tr>
<td>health care and treatment to me.</td>
<td>patients. Violent behaviour may include verbal abuse, racial or</td>
</tr>
<tr>
<td>The Trust/LHB expects all its employees to treat me with courtesy and</td>
<td>sexual harassment, threats of injury, abuse of alcohol or drugs,</td>
</tr>
<tr>
<td>respect.</td>
<td>destruction of hospital property as well as physical acts of</td>
</tr>
<tr>
<td>The Trust/LHB will only restrict or withdraw my rights to care in</td>
<td>violence.</td>
</tr>
<tr>
<td>exceptional circumstances when I have failed to comply with any of my</td>
<td></td>
</tr>
<tr>
<td>responsibilities in a manner, which is deemed unacceptable.</td>
<td></td>
</tr>
</tbody>
</table>

I confirm that I understand that if my behaviour has been unacceptable and if I do not comply with my responsibilities as a patient, then this can result in the withdrawal of my rights as a patient and I can lose my right to receive care from the Trust/Local Health Board, except for treatment in an emergency.

<table>
<thead>
<tr>
<th>Signature of Patient:</th>
<th>Signature of Named Nurse/Core Worker:</th>
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<th>Print Name:</th>
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<th>Date:</th>
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<table>
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<tr>
<th>Witnessed by:</th>
<th>Date:</th>
</tr>
</thead>
</table>
LETTER TO GP

GP’s Name and Address

Date

Dear

Re: Patient’s name

Patient’s address

Patient’s date of birth

Patient’s hospital health records number

The above individual

• Is currently an inpatient on …………………. Ward at Trust/LHB.

• Has attended A & E for emergency treatment

• Is receiving treatment from the Trust/LHB Community Nursing service

NB: The patient has been assessed to be competent in decision making.
In order to protect the clinical environment for other patients and members of staff, it has been necessary to instigate the use of a Patient Undertaking* for the above named patient.

*This being a process where the patient having displayed unacceptable standards of behaviour. Their rights and responsibilities have brought to their attention and the patient has been asked to confirm that they understand that failing to comply with these responsibilities, could result in the withdrawal of care except for emergency treatment.

If you have any queries, please do not hesitate to contact:

…………………………………………………………………………………………

(name and telephone number of patient’s consultant)

or

…………………………………………………………………………………………

(name and telephone number of general manager or head of nursing)

Yours sincerely

Signature

Name

General Manager

Note: A COPY OF THE PROCEDURE FOR USING PATIENT UNDERTAKINGS FOR THE CARE OF INDIVIDUALS WHO ARE VIOLENT OR ABUSIVE SHOULD BE ATTACHED TO THIS LETTER.
LETTER TO PATIENT

Patient’s name ........................................................................................................
Patient’s address ........................................................................................................
................................................................................................................................
................................................................................................................................
................................................................................................................................
................................................................................................................................
Hospital Number........................................

Date:

Dear ........................................

This is to formally confirm that due to your unacceptable behaviour on........................ at..................................................... you are now subject to the conditions outlined in the Trust/Local Health Board Patient Undertaking.

The first stage of the procedure for using a Patient Undertaking has been applied to you and you should have received an explanation as to why you are subject to this procedure.

Should you, on any occasion in the future, fail to comply with the expected standards of behaviour explained to you by ...................... and outlined in the Patient Undertaking, you will become subject to the next stage of the Procedure which may involve your immediate exclusion from the Trust/Local Health Board premises by our security staff/polic e. Such an exclusion from Trust/Local Health Board premises would not mean that you would not receive NHS care, as your responsible clinician would seek to make alternative arrangements for you to receive treatment elsewhere.

Yours sincerely

Signature

Name

Chief Executive
Appendix 5

Exclusion Procedure Checklist

1. The decision to exclude can only be taken by both the relevant Directorate Manager* and the relevant Clinical Director (in their absence their nominated deputies). They must be satisfied as to the capacity of the patient and that alternative care arrangements have been made. This does not preclude the relevant clinician discharging a patient who no longer requires in patient care in the normal manner.

2. The responsible consultant must be informed and write to the patient’s GP detailing the exclusion and the reasons for it.

3. The Directorate Manager will prepare a copy of the standard letter (Appendix 6), for issue to the patient. This letter should be given to the General Manager with the letter to the GP for checking both the letter and that the procedure for excluding a patient has been applied appropriately and for onward submission to the Chief Executives’ Office for signature.

4. Copies of the application of the exclusion should be maintained by the relevant General Manager and Chief Executive. A copy must be kept in the patient’s notes and recorded on the Patient’s Information System, if appropriate.

5. Copies for information must be sent to the Trust/Local Health Board Secretary, Head of Security, Health and Safety Department and Medical Director*.

6. The full process must be recorded in the patient’s medical and nursing documentation, together with a detailed record of the rationale for exclusion and of the alternative arrangements for care. The patient should be told where this material will be held.

7. Explain to the patient that the details of the exclusion will be held centrally and in the patient’s records and will be flagged on the Patient Information system when available.

8. The patient must be informed that they may challenge an exclusion via the established complaints procedure.
9. Once a system for ‘flagging’ on the Patient Information System is developed, the use of the exclusion procedure **must** be entered on this data base.

10. If an excluded individual returns in any circumstances other than a medical emergency, security staff should be called immediately. The Trust/Local Health Board will subsequently seek legal redress to prevent the individual from returning to the premises other than in a medical emergency.

11. The excluding Trust/Local Health Board may share, with other organisations, details of patients that have been excluded from their services if they feel that there may be a risk to the safety or wellbeing of other employees or patients within the health and social care sector.
Procedure for Issuing a Patient Exclusion Document
Stage 2 of Procedure for Care of Patients who are Violent/Abusive

Patient Undertaking in place for <12 months

- Further incident occurs
- No Further Incidents occur

Directorate Manager and Clinical Director contacted

- Alternative Care arrangements made
- Trust/LHB's Claims Manager informed

Exclusion letter sent by Chief Executive

- If patient attends any Trust/LHB's property security staff/police to be called
- Patient exclusion recorded in notes and in Chief Executive's office

Extend/Justify

Review Status

Remove from patient records. Inform those in loop

Patient Discharged

Patient Undertaking in place for <12 months
LETTER TO PATIENT - WITHDRAWAL OF TREATMENT/EXCLUSION FROM TRUSTS PREMISES

PATIENT'S NAME ......................................................
PATIENT'S ADDRESS .................................................
..........................................................................................
..........................................................................................
..........................................................................................
HOSPITAL NUMBER ..........................

Date: ..................................................

Dear ..........................

Further to the letter sent to you on (date), and the Formal Patient Undertaking issued, I am now writing to formally confirm that following your continued unacceptable behaviour on (insert date) at (insert venue) you are now excluded in any circumstances, other than a medical emergency, from treatment at any Trust premises.

The letter referred to above and the Formal Patient Undertaking informed you that any future failure to comply with the expected standards of behaviour within the Trust/Local Health Board may result in exclusion from treatment at any of our premises.

A detailed record of the circumstances leading to the decision is held within (specify) and you have the right to challenge the decision via the established complaints procedure by writing to the above address.

Should you return to the Trust premises you will be asked to leave, the police may be called and subsequently legal redress will be initiated to prevent further return.

The exclusion will be reviewed on (insert date - maximum one year).

Your General Practitioner has also been informed of this decision in order that alternative arrangements can be made.

Yours sincerely

Signature

Chief Executive
PART 6 : LONE WORKING

1. Due to the nature of the work within the NHS a significant number of employees are required to work alone. The section provides a policy template which can be adapted by organisations. It recognises the various risks that employees may be exposed to and advises of the action that should be taken.

2. If employees are working alone it is important to have a system in place to ensure that the alarm can be raised if they require assistance. A Specification for a Lone Worker Alert system is also contained within this section. This advises organisations of the standards that they should look for in a lone working monitoring system.
1. **Purpose**

It is intended that this policy will be a generic policy that reflects the diversity of the constituent bodies of NHS Wales, and in so doing aid the development of organisation specific policies.

A number of NHS staff routinely work alone, others may do so infrequently because particular circumstances dictate. Authoritative bodies have increasingly recognised that the risk of injury to NHS staff, from members of the public has substantially increased in recent years. Employees that work alone are more vulnerable to violence from members of the public. Furthermore lone working may mean that there are additional difficulties in obtaining assistance in the event of an incident such as accidents or vehicle breakdowns. Whilst recognising that this document is aimed at lone workers, the majority of practice can apply to other situations where staff are working remotely.

Health and safety legislation currently in force does not prohibit lone working, except in a few specific circumstances eg, working in confined spaces. The employer has a general duty under Section 2(1) of the Health and Safety at Work etc. Act, 1974, to ensure so far as is reasonably practicable the health, safety and welfare at work of employees. Further, the Management of Health and Safety at Work Regulations, 1999, requires that work activities are risk assessed. The risk assessment needs to consider options to eliminate or control a hazard in order to decrease the degree of risk to as low as is reasonably practicable. The assessment should consider the suitability of the member of staff to undertake lone worker duties.

Whereas the final procedures must be based on local conditions, this Policy will deal with generic aspects of management of risk. It provides advice on the efficacy of various control measures that may be utilised to reduce the level of risk.

2. **Definition**

This policy intentionally sets out not to identify specific groups of staff thought to be lone workers, or to delineate a specific time when lone working is deemed to occur. The overarching principle must be that lone working can occur anywhere, at
anytime and within any group of staff. The All Wales NHS Steering Group for the Management of Violence and Aggression have therefore adopted the HSE lone working definition of “those who work by themselves without close or direct supervision”.

3. **Scope of Policy**
   This policy will include all lone workers, whether they are working or acting directly or indirectly for or on behalf of the organisation.

4. **Policy Statement**
   The organisation will ensure, so far as is reasonably practicable, that staff who are required to work alone or unsupervised for significant periods of time are protected from risks to their health and safety. Measures will also be adopted to protect anyone else affected by lone working.

   Lone working exposes staff to particular hazards. The organisation’s intention is where practicable, to entirely remove the risk from these hazards or, where complete elimination is not practicable, to reduce the risk to an acceptable level.

5. **Legislative and NHS Requirements**
   For most circumstances, there are no specific legal duties on employers in relation to lone working. However, employers have a general duty under the Health and Safety at Work etc Act to maintain safe working arrangements. Regulation 3 of the Management of Health and Safety at Work Regulations 1999 also requires employers to risk assess the work that their employees undertake. Where there are more than five employees, the significant findings of the risk assessment must be recorded and reviewed regularly.

   Under Section 7 of the Health and Safety at Work etc. Act 1974, it is the responsibility of employees to take reasonable care of their own health and safety at work and that of other persons who may be affected by their acts or omissions. All staff must comply with all safety procedures/safe systems of work and approved codes of practice pertaining to their particular work activities and report all incidents that have led or may lead to injury or damage.
6. **Hazards, Adverse Incidents and Near Miss Reporting**  
Organisations must have in place arrangements for the recording of hazards, adverse incidents and near misses. It is important to ensure that if an adverse incident or hazard involves a lone worker, specific reference should be made to that fact in the recording mechanisms.

Following any adverse incident or near miss an investigation must be undertaken to identify if any lessons can be learnt. Risk assessments must then be amended accordingly.

7. **Training and Instruction**  
Training and instruction is crucial for all groups of staff that work alone and those who manage them.

This training must be relevant to the nature of the work undertaken.

Where a training need has been identified that training is mandatory and the organisation must provide it. This therefore represents a contractual requirement on the individual member of staff to undertake the training.

Training can bring about:

- a reduction in the number of incidents;
- a reduction in the seriousness of incidents;
- a reduction in the psychological effects of incidents;
- an improved response to incidents;
- an improvement in staff morale.

Training programmes and local induction should typically cover the following areas and should be identified through the risk assessment process:

- lone worker policy (including individual responsibilities);
- risk assessment in relation to lone working;
- prevention and control of risks to lone workers;
- lone working procedures;
- personal attack alarms;
theory: understanding violence and aggression;
prevention: assessing danger and taking precautions;
post-incident action: reporting, investigation, counselling and other follow up.

The aims and objectives of Violence and Aggression Training will be determined by the All Wales NHS Violence and Aggression Training Passport and Information Scheme.

Line managers are required to make adequate arrangements to ensure that staff attend courses and that training is regularly updated. Training records will provide the basis for such arrangements in accordance with the organisations training recording provision.

8. Responsibilities
8.1 The Chief Executive has ultimate responsibility for ensuring compliance with the Health and Safety at Work etc Act 1974 and the Management of Health and Safety at Work Regulations 1999 and the effectiveness of this policy.

8.2 Senior Managers are responsible for ensuring risk assessments are undertaken (see appendices), local policies and procedures are introduced; safe systems of work are adopted; training is available; health and safety training records are maintained; ensuring statutory compliance; accident/incident reporting; communication; support; liaison; and audit within their service.

8.3 Line Managers will establish and supervise safe systems of work; provide, and ensure staff have received appropriate training; and ensure that other policies and procedures are observed.

8.4 All employees are required to comply with the organisations Risk Management policies and attend training as appropriate. They should use all safety/ communication equipment at the appropriate time, and in the appropriate manner; follow the Trust’s procedures for the use of this equipment; report unsafe activities or faulty equipment to their Line Manager; report all adverse incidents or near misses using the Trust’s incident reporting system.
9. **Local Monitoring Arrangements**
   Regular local monitoring must be undertaken by organisations to ensure:
   - Lone worker incidents are being reported;
   - Safe systems are in place; and
   - Staff have received adequate training.

10. **Policy Review**
    The Lone Worker Policy will be reviewed initially after one year and then on a 3 year period or sooner if:
    - There are significant changes in work practices;
    - There are changes in legislation; and/or
    - An incident occurs that requires improvement in practice.
Appendix A – Guidance on Risk Management and Assessment for Lone Workers

The key to maximising safety wherever lone working is being considered is the performance of a satisfactory risk assessment, which should address two main features:

- Whether the work can be done safely by lone workers
- What arrangements are required to ensure, so far as is reasonably practicable, the lone worker is at no more risk than employees working together

Identify all those who may be at risk. It is important that these individuals are made aware of the outcome of the risk assessment and informed of all necessary control measures.

**Step 1 – Identifying and Analysing the Risk**
A positive, proactive and planned approach is required so that looking for hazards becomes a working habit – a natural, normal part of managing, supervising and undertaking one’s job.

Risk identification - Look for the Hazards

Some of the hazards you may wish to consider may include:

**Workplace:**
Identify hazards specific to the workplace/environment, which may create particular risks for lone workers, eg, remote areas, laboratories, workshops, confined spaces. Consider access requirements, transport and parking arrangements, etc.

**Process:**
Identify hazards specific to the work process, which may create particular risks for lone workers, eg, work on electrical systems, confined spaces, hazardous substances, work in the community, interaction with people with a known history of violent or aggressive behaviour.
Equipment:
Identify hazards specific to the work equipment, which may create particular risks for lone workers, eg, manual handling, operation of essential/emergency controls.

Individual:
Identify hazards specific to the individual, which may create particular risks for lone workers eg, medical conditions, disabilities, female employees, expectant mothers, age, inexperience, is there access to adequate rest, hygiene, refreshment, welfare and First Aid facilities, etc.

Work Pattern:
Consider the lone worker's work pattern and how it relates to those of other workers, in terms of both time and geography.

Step 2 – Assessing the Risk (please refer to the All Wales NHS Violence and Aggression Training Passport Scheme’s Risk Assessment Form)

The identification and assessment of the risks to people is particularly important.

Who might be affected?
The persons affected will range from those involved in the task - the operator, patients, students etc. or those who may not be in the work place at the time eg, domestic staff, employees walking through the area, contractors, visitors, maintenance staff or members of the public etc. The effect of a hazard can depend on a number of factors; the following should be taken into account:

individual characteristics eg, age, sex, health, etc;
young workers/trainees;
agency or bank staff;
level of training;
knowledge;
attitude;
people sharing the workplace;
visitors;
contractors;
patients.
To determine the level of risk, the following should be considered:

**Are there appropriate policies, procedures, good practice standards and guidelines in place and are they?**

- suitable?
- used?
- up-to-date?
- are there standards for record keeping?
- are there informed consent arrangements?
- are standards of care delivered?
- what measures are currently in place to prevent or control risk?
- is there a system of monitoring recurring problems?
- have staff been trained, is information available and up to date, so that staff have the knowledge to complete a task safely?
- are legal requirements being met?

Other points to be considered:

**Are your staff...**

Fully trained in strategies for the management and prevention of violence and aggression?
Briefed about the areas where they work?
Aware of attitudes, traits or mannerisms which can annoy clients etc?
Given all available information about the client from all relevant agencies?

**Have they...**

Understood the importance of previewing cases?
Left an itinerary?
Made plans to keep in contact with colleagues?
The means to contact you - even when the switchboard may not be in use?
Got your home telephone number (and you theirs)?
A sound grasp of your organisation's preventive strategy?
Authority to arrange an accompanied visit, security escort, or use of a taxi?
Do they…
Have access to forms for reporting adverse incidents or near misses?
Appreciate the need for this procedure?
Use them?
Feel confident to terminate an interview prematurely?
Know how to control and defuse potentially violent situations?
Appreciate their responsibility for their own safety?
Understand the provisions for their support by your organisation?

**Step 3 – Preventing, Eliminating, Reducing or Controlling the Risk**

Once risks have been identified and analysed, it is necessary to consider how they can be:

- eliminated?
- controlled?
- avoided?
- reduced?
- made less costly?

A range of precautionary measures needs to be considered:

- **Supervision.** The extent of supervision required will depend upon the level of risks involved and the ability and experience of the lone worker. A few examples of supervisory measures which may be useful in some circumstances, include:
  - Periodic telephone contact with lone workers,
  - Periodic site visits to lone workers,
  - Regular contact, eg, telephone, radio, etc.,
  - Automatic warning devices, eg, motion sensors, etc.,
  - Manual warning devices, eg, panic alarms, etc.,
  - End of task/shift contact eg, returning keys.

- **What to do in an emergency**

- **Training.** Identify the level and extent of training required, taking into account the nature of the lone working activity. Consider the knowledge and experience of individuals, particularly young and new workers. Lone workers should be given information to deal with normal everyday situations but should also understand when and where to seek guidance or assistance from others, ie, unusual or threatening situations, etc.
• Identify any equipment requirements; duress alarms, mobiles phones etc.

• In the case of lone workers working at the organisations premises; carry out site surveys to look at the physical security of the lone working area. Recommend any improvements.

Managers could identify unsafe areas by using a questionnaire for lone workers.

• Establish close working links with the Police, Social Services and Local Authorities. By sharing information potential risks to staff can be identified, reduced and incidents can be avoided. Under the Crime & Disorder Act lead authorities have a duty of care to provide information that may prevent the commission of an offence, in particular offences of violence.

• Negotiate agreement between the police, social services, mental health services and ambulance Trusts on effective and consistent procedures for the detention of patients under the Mental Health Act that ensure the safety of all staff. This is vital to prevent staff from different agencies clashing during emergencies because of different procedures or priorities.

• Providing a Trust/Local Health Board driver, or a taxi if appropriate, in areas where cars might be vandalised, or staff have to go through unsafe areas to make visits.

• Arranging for patients or clients to be seen at clinics rather than at home, if at all possible.

• Indicate on patient notes if a potential problem exists. This enables other health care staff to prepare and assists with risk assessments. Arranging for another member of staff or a reliable relative of the patient or client to be present during the visit, eg, if a member of staff is vulnerable to sexual harassment while visiting a member of the opposite sex.

• Traceability of staff particularly when undertaking domiciliary visits. It is vital that there are procedures in place so members of a team can be traced. Other procedures that complement this include phone-in arrangements and buddy systems.
• Organising support across different Trust/Local Health Board’s or agencies. Such arrangements exist, for example, between midwives and ambulance services or police, and between Community Psychiatric Nurses (CPNs) and social services.

• Maintaining, and adhering to, a list of types of incident that community staff working on their own are not allowed to attend, without adequate support eg, presence of police, for example, pub fights, domestic violence, overdoses and certain problem locations.

• increased security (eg, CCTV, secure access, personal alarms).

• increased lighting at entrances, exits, car parks.

Other safeguards to consider are;

• Provision of suitable items - dependent on the level of risk - such as mobile phones, Global Positioning Systems (GPS) and personal alarms. It is strongly recommended that mobile phones or GPS systems are linked to a response centre in order that an appropriate and timely response can be carried out. Appropriate training should be provided in the use of any of these items;

• Awareness of driving/parking in built-up areas and suitability of vehicles. For example, parking in well-lit areas, close to where you are visiting;

• Personal awareness including what belongings are being carried/worn, eg, jewellery;

• Appropriate training, for example, personal safety training including acknowledging and diffusing potentially difficult situations.
Step 4 – Recording

It is essential that appropriate control measures are in place and maintained. It is therefore necessary to record all significant findings of a risk assessment. This involves completing a risk assessment form and preparing an action plan.

The main findings of the risk assessment must be recorded including:

- hazards;
- staff groups affected;
- existing preventive measures;
- evaluation of remaining risks;
- additional measures needed.

It is important that the following is implemented within each ward, department or directorate. The risk assessment:

- should be kept in the immediate workplace;
- should be brought to the attention of staff and available at all times;
- must be kept for future reference, as they may be required by external agencies such as solicitors, health and safety inspectors or internally by safety representatives and managers;
- must be dated and signed at time of assessment and when updated;
- must be updated in writing when any change occurs.

The findings of a risk assessment should be used to draw up an action plan of the remedial measures required to reduce the risk to as low as is reasonably practicable. Staff must be informed of the risks and the action.

The risk management plan should clearly identify the priority order in which the risk remedial measures should be implemented. Factors influencing the priority order might include:

- the assessed level of risk following evaluation and reference to the risk assessment matrix;
• the influence of any external factors eg, statutory requirement, NHS Executive requirement, political pressure;
• the result of any cost benefit analysis in relation to implementing the treatment option;
• the potential for causing injury or ill health to people;
• the potential for a claim for compensation;
• the potential for serious loss of reputation;
• the potential for serious delays in service delivery.

A training needs assessment must be undertaken for all staff and training records must be maintained.

**Step 5 – Monitoring and Review**

On going monitoring is essential to ensure that the systems of work identified following risk assessment are being complied with. Observation by an appropriate line manager should be supplemented by formal systematic examination of work activities.

In addition risk assessments will need to be regularly reviewed and updated particularly if it is suspected that they are no longer valid eg, where there has been a significant change. This will be required when equipment, machinery, substances, technology, legislation, evidence based research practices and procedures etc, are changed.

There are a number of aspects to an effective monitoring regime:

• routine inspection of control measures;
• ensuring correct use of control measures;
• ensuring full implementation of systems and policies;
• ensuring staff are fully aware of risks;
• monitoring - to measure performance;
• reviewing incident statistics;
• undertaking regular environmental safety inspections, clinical and quality audits;
• implementing appropriate training programmes.

The risk control measures will be continually refined through adequate monitoring arrangements which will vary depending on the nature of the activity and risk assessment findings. This will result in demonstrable improvements which will be communicated to staff.
PROJECT DOCUMENTATION

OUTPUT BASED SPECIFICATION

LONE WORKER ALERT SYSTEM

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1. **Introduction**  
Under the Health and Safety at Work etc Act 1974, the NHS in Wales has a duty to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all employees and others affected by its work activities.

The definition of a lone worker would be best described as someone who works alone without direct or close supervision. This generally, but not always, means being remote from others.

The All Wales NHS Steering Group for the Management of Violence and Aggression recommends that all NHS organisations across Wales provide a means of automatically providing help for a Lone Worker, when required. The main purpose of this guidance is to provide a procurement specification for a Lone Worker monitoring system. Therefore any supplier/manufacturer must demonstrate that their system will meet set, predetermined criteria.

2. **Scope**  
2.1 The guidance specification is to assist organisations in the lease or purchase of a lone worker monitoring system, to include installation and implementation of the application software, hardware, communications, support and training.

2.2 Any such system must be capable of being installed in multiple locations, providing capacity for existing requirements and future expansion.

2.3 The following headings and criteria should be included in any specification and tendering document.

3. **Timescale**  
The system is scheduled to be implemented during (please specify).

4. **Instructions to Suppliers**  
4.1 The supplier is requested to state that they can and are willing to meet the requirements as set out in the specification. Products must be described in terms of their current status and not in terms of their expected development. Additional comment on proposed developments may be supplied for information but must clearly be identified as such.
4.2 Suppliers must respond to each of the statements in the specification. Suppliers must order their responses under the numbered headings in the order in which they appear.

4.3 Suppliers must:

a) Reply explicitly to each referenced statement number.
b) Reproduce in their proposal both every referenced statement and their response to it.
c) Where information is requested, provide full details of how the requirement is to be met.
d) Give their responses in the positive, i.e., “DOES” not “CAN” and “WILL” not “SHOULD” thus giving a definite rather than objective statement of the proposed system’s capabilities.

4.4 If the supplier’s product can wholly satisfy a requirement, it will be sufficient for them simply to respond “COMPLIANT” to a statement. If the product does not satisfy the requirement, the supplier should respond “NOT COMPLIANT” and give an indication of how/if they intend to modify their product to meet the requirement and the timescale for the implementation of this modification.

5. **The Supplier**

This section specifies characteristics which the supplying organisation must be able to demonstrate in order to be considered.

5.1 Must have a significant user base for its products within the NHS or other large organisations. Please also provide list of reference sites.

5.2 Must have sufficient resources to be able to provide an acceptable level of support to its users.

5.3 It is desirable that the supplier must have a user group that meets regularly to discuss enhancements to the product. Also there must be allowance for regular meetings with the supplier to discuss timescales for any suggested changes.
6. **Requirements of the System**

This section specifies general system requirements which must be met in order for the product to be considered. The supplier must also provide full technical specifications for all components of the proposed system.

The proposed system must:-

- Meet demand of lone working members of staff across NHS organisations in Wales to provide a system to meet anticipated demand
- be simple to operate and to understand by all users
- be capable of supporting remotely 24 hours a day, 7 days a week. This includes statutory holidays.
- be updated/upgraded on a regular basis as company learning becomes evident
- support either analogue or digital connections to suit the client’s telephone equipment
- have management reporting systems on the activity of users
- be able to utilise web based reporting mechanisms
- work automatically in sending an alert to a predetermined telephone number(s) and/or PC’s or other IT systems
- be capable of following multiple pre-determined escalation plans
- allow the lone worker to utilise the speed dial facility on their mobile telephones if required
- be password protected
- be capable of being used with any tone/MF Keypad
- be able to integrate with current network and apparatus in use
- have proven compliance with the Data Protection Act 1998
- allow incident information to be archived
- allow audit trails of all incidents and daily activity
- allow the user to have the ability to call for help unobtrusively
- be capable of linking with a GPS system.
7. **System Characteristics**

7.1 Availability

The system **MUST** be fully capable of being available for use 24 hours a day, 7 days a week. This includes statutory holidays.

7.2 System Security and Audit Trails

7.2.1 The system **MUST** be capable of identifying a lone worker through an inputted identification number or a mobile phone calling line identification.

7.2.2 The system **MUST** have the facility to support the use of electronic signatures eg, Personal Identification Numbers (PIN).

7.3 System Provision

The system **MUST** be capable of recovering to the last known entry should it crash or fail in any way.

7.4 Back-Up, Recovery and Data Integrity

7.4.1 The system **MUST** enable the back up of the data files and support remote backup.

7.4.2 The system **MUST** enable all back-ups to be completed and verified with no effect on the required availability or response times of the system and be capable of being performed without operator intervention.

7.5 System Operations

The system **MUST** enable operator intervention to be kept to a minimum and the system **MUST** be fully capable of operating outside normal working hours without operators being present.
8. **Training**
A training programme **MUST** be fully agreed prior to implementation. This will include administrator training with guidance and support materials. This **MUST** include the time involved, proposed location, pre-requisites, requirements and intervals for follow-on refresher courses, and a full breakdown of the costs involved.

9. **Documentation**
The system **MUST** be fully documented in all aspects by the programme and a full operating manual must be available.

10. **The Selection Criteria**
The assessment will be based on the following in no particular order

- prices and rates
- training resources
- response
- experience in the industry
- quality of hardware
- added value
- financial status
- maintenance levels year on year
- flexibility of system
- a roadmap of future developments
- reference sites feedback.

**ANY REMOTE ACCESS MUST COMPLY WITH THE NHS CODE OF CONNECTION REQUIREMENTS**
REFERENCES

Health and Safety at Work etc. Act 1974.

Management of Health and Safety at Work Regulations 1999.

Data Protection Act 1998

Human Rights Act 1998

Mental Health Act 1983

Mental Health Act 1983 : Code of Practice (1999), Department of Health and Welsh Assembly Government

Crime and Disorder Act 1998

We Don’t’ Have to Take This – NHS Zero Tolerance Zone (1999)

HSC 1999/226 – Campaign to stop violence against staff working in the NHS : NHS Zero Tolerance Zone, Department of Health

HSC 2001/18 – Withholding Treatment from Violent and Abusive Patients in NHS Trusts, Department of Health


The recognition, prevention and therapeutic management of violence in mental health care, (February 2002), United Kingdom Central Council for Nursing, Midwifery and Health Visiting (Nursing and Midwifery Council)

A Safer Place to Work – Protecting NHS Hospital and Ambulance Staff from Violence and Aggression, (2003), National Audit Office

Mental Health Policy Implementation Guide – Developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health In-Patient Settings, (2004), National Institute for Mental Health in England
All Wales Violence and Aggression
Training Passport and Information Scheme


All Wales NHS Manual Handling Training Passport and Information Scheme, 2003 prepared by The All Wales NHS Manual Handling Steering Group

All Wales Child Protection Procedures

Client/Contractor National Safety Group (CCNSG) Safety Passport Scheme

Counter Fraud and Security Management Services Guidelines
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