

THE NATIONAL ASSEMBLY FOR WALES

AUDIT COMMITTEE

Report presented to the National Assembly for Wales on 22 March 2006 in accordance with section 102(1) of the Government of Wales Act 1998

Protecting NHS staff from violence and aggression

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Summary

NHS staff in Wales face unacceptably high levels of violence and aggression at work, with staff reporting an average of 22 incidents of verbal or physical abuse every day. NHS trusts in Wales spent some £6.3 million in 2003-04 on the consequences of violent incidents and the prevention of further incidents through training and security. In 2004, the Welsh Assembly Government launched the All Wales NHS Violence and Aggression Training Passport and Information Scheme (the Passport Scheme) to provide guidance to NHS staff on developing policies on various aspects of protecting staff from violence.

On 10 November, on the basis of a report by the Auditor General for Wales,¹ we took evidence about protecting NHS staff from violence in NHS trusts from Mrs Ann Lloyd, Head of the Welsh Assembly Government's Health and Social Care Department and Chief Executive to the NHS in Wales, and from Mr Gren Kershaw, Chief Executive of Conwy and Denbighshire NHS Trust and Accounting Officer for the Welsh Risk Pool.

Our report examines, in the light of this evidence, whether the Welsh Assembly Government and NHS trusts are doing enough to protect NHS staff from violence and aggression at work. It concludes that:

- a) data on the incidence and causes of violence and aggression is not yet fully comprehensive;
- b) an all-Wales approach to violence has started with the Passport Scheme and performance management is improving; and
- c) NHS trusts are complying with their legal obligations and good practice guidelines to protect staff but need additional support in key areas.

Data on the incidence and causes of violence and aggression is not yet fully comprehensive

It is imperative that managers understand the extent of health and safety problems if they are to manage them effectively. Whilst staff reported around 8,000 incidents of violence and aggression during 2003-04, this by no means represents a full picture of

¹ Report by the Auditor General for Wales: *Protecting NHS Trust staff from violence and aggression*, published 22 September 2005.

the extent of violence and aggression in NHS trusts because of under-reporting. Furthermore, NHS trusts do not routinely collect data on the causes or nature of reported incidents. As a consequence:

- a) from the data available, it is not possible to tell whether a person's violent or aggressive behaviour is avoidable or related to their medical condition, for example with elderly mentally infirm patients or people recovering from anaesthetics;
- b) there has been a lack of demographic data which could help quantify the level of attacks that are directed towards people due to their race, gender or age;
- c) trusts have historically used inconsistent definitions of violence and aggression, although a standard definition of what constitutes violence and aggression is now available in the Passport Scheme; and, while training to encourage reporting is widespread, staff still vary in their willingness to report every incident and in their personal interpretation of the definition;
- d) sickness absence data does not capture whether the absence was caused by violence and aggression in the workplace, which significantly compromises the Assembly Government's understanding of the impact of violence and aggression; and
- e) because of a lack of confidence in the figures, NHS Wales does not have robust trend data about the extent of the problem of violence and aggression.

An all-Wales approach to violence has started with the Passport Scheme and performance management is improving

Violence and aggression have a serious and detrimental effect on the lives and careers of individual members of staff affected by incidents. It also affects the ability of NHS trusts to care for patients – in 2003-04, NHS Wales spent £6.3 million on training and security, the costs of covering staff absence and legal costs. The Passport Scheme was launched in 2004 to provide guidance to NHS staff on developing policies on various aspects of protecting staff from violence. Developments in this area include:

- a) requiring all NHS trusts to send reports to the Welsh Assembly Government's Health and Social Care Department by March 2006 detailing how they will implement the Passport Scheme and what support they need to deliver training

as the Welsh Assembly Government has already identified trusts which are unable to train all staff before 2008;

- b) improving unsafe environments that persist, particularly in mental health units;
- c) a specific target for the reduction of violence has been removed from the Assembly's performance targets for trusts - it may have represented a perverse incentive against reporting incidents and there was no reliable baseline data;
- d) the Assembly Government's performance management arrangements are now based on a balanced scorecard approach, which emphasises continuous improvement, and on the Welsh Risk Management Standards, which support trusts in their continuing development of good risk management practice.

NHS trusts are complying with their legal obligations and good practice guidelines to protect staff but need additional support in key areas

NHS trusts are complying with their legal obligations and good practice by developing appropriate policies to protect staff, conducting risk assessments of violence and aggression, enhancing the physical environment, providing security services and training staff. However, there are a number of areas where trusts need further support:

- a) providing further guidance on managing patients who are repeatedly behaving in a violent manner;
- b) in developing better relationships with the police as a number of NHS trusts were dissatisfied with the response of the police when called to incidents; and
- c) securing prosecutions, when this is appropriate.

Recommendations

- i. Although the Welsh Assembly Government has clarified the definition of violence and aggression and increased levels of training through the Passport Scheme, some staff are still reluctant to report every incident of violence and aggression. There are gaps in the information collected about the nature and causes of reported incidents, and a lack of information on the demographics of the staff concerned. Nor are sickness absence reporting systems sufficiently robust to identify the level of staff sickness absence that is related to violence. **We recommend that:**
 - a) **NHS trusts encourage staff reporting of incidences of violence and aggression by seeking to reduce the burden of form filling for front line staff, for example by encouraging security or administrative staff to complete the forms;**
 - b) **all information on the causes of incidents of violence and aggression – for instance, where an interview with a manager has taken place after an incident, or as part of an exit interview with staff leaving the Trust’s employment – should be passed to the Trust’s health and safety lead, who should analyse the causes of violence and share any emerging trends with the Trust Board; and**
 - c) **the Welsh Assembly Government and NHS trusts should develop sickness absence reporting systems that record work-related violence as a reason for absence.**
- ii. NHS trusts are required to provide annual statistics for violence to the Welsh Assembly Government’s Health and Social Care Department as part of the balanced scorecard for 2005-06. **We recommend that the Welsh Assembly Government uses its performance management system to provide all NHS trusts with benchmarking data to enable them to compare their violence statistics with those from similar trusts and departments on an annual basis and to assess their rates and performance in handling violence and aggression.**
- iii. Delays in discharging patients exhibiting disturbed behaviour, such as elderly patients with dementia, may increase the risk of violence and aggression to staff. Trusts do not have data on the number of incidents caused by elderly patients delayed on wards due to a lack of alternative care. **We recommend that trusts**

seek to reduce the risk of violence and aggression by carrying out risk assessments on the impact of any delayed transfer on a patient's mental health, and that ward managers ensure that staff are adequately supported where a delayed transfer of care exacerbates the risk of violence from patients.

- iv. The Auditor General's report highlighted a number of legal issues that NHS trusts were wrestling with, namely, how to increase the number of successful prosecutions, working more effectively with the police, and the data protection and human rights issues that surround tagging the notes of repeatedly violent patients and sharing this information across agencies. The Welsh Assembly Government is carrying out work in each of these areas to provide further support and guidance to trusts. **We recommend that the Welsh Assembly Government issues guidance to NHS trusts on increasing prosecutions, working with the police, and the data protection and human rights of patients. The Assembly Government should monitor the impact of this guidance on staff well-being and on the development of effective management systems by trusts.**

Data on the incidence and causes of violence and aggression is not yet fully comprehensive

1. Mrs Lloyd told us that the NHS in Wales has to get to grips with the numbers and causes of violence and aggression against staff, as it cannot tackle the problem if it does not understand its scale. Clearly, it is vital that NHS trusts, and Welsh Assembly Government officials, have consistent and accurate data on the extent of the problem of violence and aggression.² We recognise the point, emphasised by Mr Kershaw on the need to look beyond statistics in assessing performance as a large number of incidents may reflect a strong culture within the Trust of reporting or, as noted by Mrs Lloyd, a heightened awareness among staff, following training, about the necessity to report violence or aggression against them.³ Nevertheless, the NHS Wales can further improve the information it has about the incidence of violence and aggression, as:
 - a) NHS trusts do not routinely collect data on the causes of violent incidents;
 - b) NHS Wales has no data on the level of violence against particular groups of staff; and
 - c) historical inconsistencies of definition and recording make it difficult to monitor trends in incidence and impact.

NHS trusts do not routinely collect data on the causes of violent incidents

2. The Auditor General's report found that in 2003-04, NHS Trust staff reported about 8,000 incidents of violence and aggression – the equivalent of 22 incidents occurring each day in Wales. Mrs Lloyd agreed with us that it is totally unacceptable that NHS staff suffer from assaults, threats and abusive language when they are trying to help and care for people.⁴ The level of violence is likely to be higher in the health service than in general society as NHS staff provide care to all kinds of people, such as those who have serious mental health problems, as well as for people who are confused, anxious or stressed by being in a hospital environment.⁵

² Qs 19 and 25

³ Qs 4, 9 and 21

⁴ AGW report, paragraph 1, Qs 1 and 2

⁵ AGW report, paragraph 1.1, Q2

3. Mrs Lloyd explained that the figures included violence and aggression arising from a patient's medical condition. Some people cannot help being aggressive, for example, someone coming round from anaesthetic may unconsciously respond violently. The same could be true of someone with mental health problems or for elderly and confused patients. However, Mrs Lloyd said that data systems were too unsophisticated to distinguish between these circumstances, and the type of incident where someone comes into accident and emergency departments perhaps having overindulged in alcohol or drugs, and who becomes violent. Consequently the information held by trusts about the nature of the incident is based on assumptions on where and what time the incident occurred or from the Health and Safety Executive.⁶
4. We wanted to know whether holiday makers are more likely to commit violent acts on hospital staff in the summer months. Mr Kershaw subsequently provided information which indicated that there was no definitive relationship between the summer months and the reported levels of violence and aggression in accident and emergency at Conwy and Denbighshire NHS Trust which suggests that holiday makers are not a contributing factor to the problem.⁷
5. A particular problem raised by the Auditor General was the level of violence in general medicine wards, which was running at three times the rate for accident and emergency departments.⁸ Mrs Lloyd explained that there are many more clinical interventions with patients on medical wards compared with accident and emergency departments, and that many elderly and confused patients can be difficult to treat. She also said that relatives sometimes misinterpret what is happening when a patient needs to be restrained in order for treatment to go ahead and can respond violently.⁹
6. We were concerned about the numbers of elderly mentally infirm patients delayed on medical wards because transfers of care were not available. Mrs Lloyd assured us that there had been good progress in reducing the numbers of delayed transfers of care in Wales although there is still more work to be undertaken with local government partners to ensure a smooth transfer of care at an appropriate time. The

⁶ Q3

⁷ Qs 38, 42 and Annex B

⁸ AGW report, paragraphs 1.19 and 1.20 and Figure 8

⁹ Q10

risk assessment for patients who are delayed in hospital needs to consider the impact of such delays on their mental health and it is important that the ward manager is able to ensure that staff are appropriately supported.¹⁰

NHS Wales has no data on the level of violence against particular groups of staff

7. The Committee was interested to know whether NHS Wales collects information on which groups of staff are being most affected by violence. In particular, we wanted to know whether there was any evidence of racially-motivated attacks, whether male or female staff were at higher risk, or whether younger staff were more susceptible than older staff. Mr Kershaw said that he knew that there was some racially-motivated abuse of staff at Conwy and Denbighshire NHS Trust and that this was not confined to accident and emergency departments. However, he had no information as to the gender or age of staff reporting violence and aggression. Mrs Lloyd admitted that such information was imprecise at the moment but that the Electronic Staff Record will help NHS Wales to analyse incidence by demographic factors when it comes on stream next year. She added that this is particularly important given the need for NHS Wales to comply with anti-discrimination legislation.¹¹

Historical inconsistencies of definition and recording make it difficult to monitor trends in incidence and impact

8. The Auditor General reported that there had been seven different definitions for violence at work in use across NHS trusts in Wales.¹² Mrs Lloyd told us that definitions were being standardised between trusts as part of the Passport Scheme and increased training should help staff interpret that definition, to be clear about what constitutes an incidence of violence and aggression.¹³ Staff were being encouraged to report all incidents of violence. For instance, one NHS Trust in Wales was looking at electronic reporting, although there can be disadvantages in such systems if nurses have to take the patient's record off the screen to look for a form on a separate part of the system. Mr Kershaw emphasised that it was an issue for leadership in trusts to ensure that staff report when they have been abused or

¹⁰ Q12

¹¹ Qs 70 and 71

¹² AGW report, paragraph 1.30 and Appendix 6

¹³ Qs 19, 25, 27 and 33

threatened.¹⁴ Despite improvements in reporting, Mrs Lloyd acknowledged that she was not confident that they yet had a full understanding of the extent of violence and aggression in NHS trusts. Nonetheless, she noted that the levels of reported incidents were decreasing even though they might be expected to rise with the heightened awareness among staff about the necessity to report (through training and campaigns).¹⁵

9. Trusts do not routinely hold information on the extent of sickness absence due to violence and aggression. Mrs Lloyd said she was still concerned that they do not currently have a sufficiently good system for reporting the information, which significantly weakens the department's understanding of the impact of violence and aggression.¹⁶ The Auditor General reported that seven trusts had told him that violence and aggression had caused problems for recruitment and retention, particularly in the areas of mental health, medical admissions and accident and emergency.¹⁷ Mr Kershaw told us that he did not think that violence had affected recruitment and retention in his own Trust. Exit interviews with some 60 per cent of staff leaving the Trust's employment, had not indicated that violence was a factor in the decision to leave. We were also concerned that staff shortages might lead to an increase in the levels of violence occurring on the wards. Mr Kershaw was not aware of this problem and said that by working with staff groups, the unions and the Trust's health and safety committee, he should be made aware if staff shortages were leading to increasing levels of violence, and would take appropriate action if this came to his attention.¹⁸

An all-Wales approach to violence has started with the Passport Scheme and performance management is improving

10. The Auditor General estimated that the cost of violence in NHS Wales in 2003-04 was £6.3 million with two thirds of this amount spent on training and security costs while legal cases and replacing staff after an incident made up the remaining third. Mrs Lloyd told us that the whole principle behind establishing an all-Wales Passport Scheme and, in particular, emphasising the requirement for training and

¹⁴ Qs 19, 21, 25 and 27

¹⁵ Qs 19 and 21

¹⁶ AGW Report, paragraph 1.25, Q25

¹⁷ AGW Report, paragraph 1.27

¹⁸ Qs 14 to 18

development, should change the allocation of resources so that more goes into training and preventative measures, and less into responding to violence and aggression due to fewer incidents.¹⁹ This section looks at:

- a) the future development of the Passport Scheme to cover mental health units and provide further support to trusts on their lone worker policies;
- b) providing time for staff to undertake training;
- c) performance management of violence and aggression through the balanced scorecard rather than annual targets in the Service and Financial Framework; and
- d) the role of the Welsh Risk Pool.

The Passport Scheme is being developed to cover mental health units and lone worker schemes

11. Mrs Lloyd confirmed that the NHS in Wales was working towards a zero tolerance approach to tackling violence and intimidation. She told us that the all-Wales working group for the Management of Violence and Aggression, which produced the Passport Scheme, started to look at health and safety and the management of violent incidents three or four years ago. This was the beginning of an all-Wales approach and, in July 2005, the Welsh Assembly Government had issued the Security Management Framework for NHS trusts in Wales. One area of particular interest for further development is in mental health services, where NHS Wales is using the reports prepared by the Healthcare Commission and Royal College of Psychiatrists on the management of violent patients.²⁰ Mrs Lloyd said that there was also an all-Wales development of a lone worker scheme with an accompanying alarm system.²¹

New contracts should provide staff with sufficient time for training

12. The Passport Scheme is a tool to help trusts to improve their management of violence and the consistency of training provided across all trusts. However, the Auditor General's report highlighted the problems that trusts experience in releasing staff to attend mandatory training sessions.²² Mrs Lloyd explained that trusts have to

¹⁹ AGW report, paragraph 1.28 and Figure 13, Q13

²⁰ Qs 36, 37 and 43

²¹ Q43

²² AGW report paragraph 2.7

comply with the Passport Scheme and are due to report, by the end of March 2006, on how they intend to do so, including their training assessments. She said that some trusts had already submitted their reports; showing that for some trusts it could take until 2008 to fully implement the required training for all staff. Her staff were therefore discussing with trusts how to prioritise training for those staff most at risk. She acknowledged that the problem of releasing staff for training is a constant problem in the NHS and should be addressed with the *Agenda for Change* and the new consultants' contract by providing sufficient time for key training, including all elements of health and safety.²³

13. Mr Kershaw told us that more than 600 staff at his Trust have received the mandatory training, and that they have to pull staff away from ward work to receive training. Consequently, they are trying different ways of providing training, for example by training new staff in the week before they start their employment with the Trust. He believed that there are still opportunities to develop e-learning and that new initiatives that move away from classroom based learning could be developed further to help reduce the impact of staff being away from the wards.²⁴

The Assembly Government has moved away from setting hard targets for reducing the number of incidents

14. The Auditor General's report highlighted the problems with the Service and Financial Framework target, set in 2002-03, for trusts to reduce the number of incidents of violence and aggression by 10 per cent by 2004. There was an inadequate baseline against which to measure progress, and the quantitative target may have acted as a perverse incentive against the full reporting of incidents. The new performance improvement framework for trusts does not mention violence at all.²⁵
15. Mrs Lloyd told us that the Welsh Assembly Government had set a target for reducing violence and aggression because of the necessity to improve the recording and management of violence by NHS trusts. The target originated from recommendations in the Health and Safety Executive's *Revitalising Health and Safety* strategy and was prioritised because the Minister and Mrs Lloyd were concerned about the health and well-being of staff. However, Mrs Lloyd recognised

²³ Qs 47 and 48

²⁴ Q49

²⁵ AGW report, paragraphs 2.8 and 2.9

that, as with some other targets, the recording systems at the time were insufficient to monitor progress. After taking advice, she decided that the theme of improving health and safety would be promoted more effectively through the balanced scorecard approach to performance management and the outcomes of Welsh Risk Pool assessments against the Welsh risk management standards so that staff and other interested parties can see in an open and transparent way how well their organisation is performing over time.²⁶

16. Mr Kershaw said that he did not think that managing the threat of violence against staff was an area that lends itself easily to quantitative targets, largely because of the lack of conciseness about definitions. He concurred with Mrs Lloyd that through performance management, leaders of NHS bodies need to have the protection of staff sufficiently high on their agendas and have local systems in place to enable them to monitor their own progress.²⁷ With greater consistency of definition, both the Welsh Assembly Government and trust management should be able to monitor trends in violence and aggression much more effectively than had previously been the case.

The Assembly Government monitors performance against Welsh Risk Pool assessments

17. The Welsh Risk Pool, which is managed by Conwy and Denbighshire NHS Trust, exists to assist NHS trusts and Local Health Boards to develop effective risk management systems, through the application of risk management standards, and the settlement of legal claims.²⁸ Mr Kershaw explained that the standards, developed with NHS Wales, contained all their legal and regulatory obligations. Some “controls assurance” standards, such as the security standard, only require self-assessment by health bodies, whilst the other 24 standards are assessed by the Welsh Risk Pool, including those for mental health, community working and accident and emergency. The Welsh Risk Pool reports the results of these assessments to health bodies, as well as to Mrs Lloyd to provide a national perspective on performance.²⁹

²⁶ Q43

²⁷ Q44

²⁸ AGW report paragraphs 2.10 to 2.12

²⁹ Q45

18. We were concerned that the results of the assessments showed that three trusts had not met the 75 per cent target in all standards. Mrs Lloyd assured us that every trust met all the core standards, namely those on risk management systems, risk profiles, adverse incident and hazard reporting, communication, consent to treatment, audit and supervision. Furthermore, the relevant regional offices were working with the three trusts that did not reach the 75 per cent compliance target in all 24 standards to improve their performance.³⁰
19. Whilst the Welsh Risk Pool has not produced a report specifically on violence, it did assess night time security as part of one of the assessments completed this year. They found five trusts did very well, one trust did not do well and the rest were in between. The Welsh Risk Pool shared the results of the assessments with the trusts and for the one trust that did less well they went back to the trust to explain their concerns.³¹

NHS trusts are complying with their legal obligations and good practice guidelines to protect staff but need additional support in key areas

20. The safety and protection of staff is a legal obligation of all NHS employers, and there is a lot of good practice to guide their efforts to comply. This section looks at how NHS trusts seek to meet their legal obligations as well as the areas where there is scope for additional support from the Welsh Assembly Government, in particular:
- a) the importance of environmental risk assessments;
 - b) improving unsafe environments;
 - c) developing better relationships with the police;
 - d) advice on legal issues around dealing with patients who are repeatedly violent;
and
 - e) helping staff to take out prosecutions.

³⁰ AGW report paragraph 2.11, Q46

³¹ Q45

Environmental risk assessments and actions have been targeted on high risk areas

21. The Auditor General reported that the proactive assessment of the risk of violence and aggression, supported by appropriate action to minimise any risks identified, is the basis of the effective management of violence and aggression, as well as compliance with health and safety legislation. We were concerned to see in the report that Conwy and Denbighshire NHS Trust did not carry out generic risk assessments of buildings unless something was specifically remiss.³² Mr Kershaw told us that his Trust operates out of 60 buildings including a large and complex district general hospital. Mr Kershaw agreed that in an ideal world they would risk-assess the environment in all locations but that his Trust had taken the view that they should only risk-assess the areas that they already know are problematic in addition to risk assessment of individual patients. Thus they were concentrating on the areas where they know there are problems and which they regard as the priority.³³ Mrs Lloyd agreed that a practical approach to risk assessment and the management of the environment was acceptable because it was important for the leadership within an organisation to channel resources and efforts to those areas that represent the greatest risk to staff, although general risk assessment throughout the rest of the organisation was also necessary.³⁴

High rates of violence occur in mental health units and unsafe environments persist

22. The Auditor General's report shows that rates of violence are high in mental health settings with 23 per cent of reported incidents occurring there. The Royal College of Psychiatrists has produced a list of eight factors that influence violence in mental health settings.³⁵ Mrs Lloyd told us that the risk factors listed by the Royal College of Psychiatrists are those which should be considered in risk assessments, when designing new wards or adapting existing wards; wards need to be safe for all the different types of patients, such as those with substance misuse problems or those with a more forensic type of mental health problem. She said that there has been a very large investment in constructing new mental health facilities in Wales over the past five years but there are still problems with some facilities. Plans for mental

³² AGW report, paragraph 2.26

³³ Qs 51 and 52

³⁴ Q54

³⁵ AGW report, paragraphs 1.17 and 1.18 and Figure 10

health services need to consider the sort of environment that will be appropriate for the patients in the future, especially with the move towards more community-based care. Although we recognise that NHS Wales is developing solutions to these problems, particularly through the building of new units, we remain extremely concerned about the incidence of violence and aggression in mental health settings.³⁶

The Welsh Assembly Government is encouraging trusts to develop better relationships with the police

23. Four trusts reported that they believed that the response by the police to violent incidents was either fairly unsatisfactory or very unsatisfactory.³⁷ Mrs Lloyd said she had asked her officials to look into trusts' perceptions of the adequacy of the police response to incidents. She subsequently informed us that not all trusts have formal mechanisms for liaison with the police in place. In future, all trusts should be involved with their local community partnerships through which health, social care, the police and probation and other key stakeholders work together. Mrs Lloyd told us that she has asked officials to liaise with the Welsh Risk Pool to ensure that this requirement forms part of one of their risk management standards.³⁸ Mrs Lloyd said that she was encouraging the full participation of the health service and social care in community partnerships to secure the benefits from the successful community partnership working that have emerged in many parts of Wales.³⁹
24. Mr Kershaw said that Conwy and Denbighshire NHS Trust has a police officer who spends 50 per cent of his time based in the hospital and he can easily be called upon because he works in the local vicinity. The Trust's accident and emergency staff have a very positive and constructive relationship with the police, and other staff have developed good relations with the police through issues that are not just related to violence.⁴⁰

³⁶ Qs 5 to 8

³⁷ AGW report, paragraph 2.41

³⁸ Q55 and Annex B

³⁹ Q57

⁴⁰ Q56

The Passport Scheme provides guidance on the management of patients who repeatedly cause violence

25. A very small number of patients and visitors can cause a large number of incidents.⁴¹ Mr Kershaw reported that one patient has been responsible for 125 violent incident reports but that this person was undoubtedly ill. Conwy and Denbighshire NHS Trust has implemented a 'contract of care' policy whereby yellow cards are given to patients who are violent as a warning, and red cards for serious offences. Since the scheme was introduced in 2002, Mr Kershaw said that the Trust has issued five yellow cards and one red card. The Trust does not routinely circulate the names of yellow-carded patients within the Trust; clearly, the identity of the solitary red-carded individual is well known to staff and security staff.⁴² The Trust contacts the patient's general practitioner when a red or yellow card is issued.⁴³ However, Mr Kershaw did not know whether the Trust regularly shared this information with social services.⁴⁴ The NHS does share information about some patients, for example those that have Munchausen syndrome, through the alert system that is in place across the country.⁴⁵
26. We asked about the progress made by the Welsh Assembly Government on the issues relating to the Human Rights Act 1998 and data protection. Mr Kershaw felt that there were difficulties in sharing information about a person who has committed one offence and who may not acknowledge that their action constitutes an offence.⁴⁶ However, the need to safeguard staff is greater than protecting the individual rights of the patient if they are causing distress to staff.⁴⁷ Mrs Lloyd said that some progress has been made through guidance contained in the Passport Scheme but that she is clarifying the legal position that will underpin the actions of staff in sharing information about problem individuals across agencies.⁴⁸

⁴¹ AGW report, paragraphs 1.10 and 2.42

⁴² Qs 56, 58 and 59

⁴³ Q62

⁴⁴ Q63

⁴⁵ Q64

⁴⁶ Q62

⁴⁷ Q64

⁴⁸ Qs 60 and 61

Prosecutions are still difficult to secure

27. The Auditor General's report describes the problems faced by individuals in trying to prosecute someone who has committed a violent offence against them.⁴⁹ Mrs Lloyd agreed that this was a problem and that the Welsh Assembly Government is working with Welsh Health Legal Services to determine the extent to which NHS organisations can act on behalf of a member of staff to secure a criminal conviction. She acknowledged that Assembly Members are lobbying for attacks on emergency personnel to become a criminal offence, and that anything that employers could do to share responsibility with employees for prosecutions might ease the pressure on individual employees who have experienced the distress of a violent incident. In addition, NHS Wales is working with the NHS Counter Fraud and Security Management Service in England to try to overcome the difficulty of securing prosecutions.⁵⁰

⁴⁹ AGW report, paragraphs 2.46 to 2.50

⁵⁰ Qs 65 and 66



**Cynulliad Cenedlaethol Cymru
Y Pwyllgor Archwilio**

**The National Assembly for Wales
The Audit Committee**

**Dydd Iau, 10 Tachwedd 2005
Thursday, 10 November 2005**

Aelodau Cynulliad yn bresennol: Janet Davies (Cadeirydd), Leighton Andrews, Mick Bates, Alun Cairns, Jocelyn Davies, Mark Isherwood, Irene James, Denise Idris Jones, Carl Sargeant, Catherine Thomas.

Swyddogion yn bresennol: Gillian Body, Swyddfa Archwilio Cymru; Jeremy Colman, Archwilydd Cyffredinol Cymru; Paul Dimblebee, Swyddfa Archwilio Cymru; Ian Gibson, Dirprwy Swyddog Cydymffurfiaeth, Cynulliad Cenedlaethol Cymru; Ann Lloyd, Pennaeth yr Adran Iechyd a Gofal Cymdeithasol; Elaine Matthews, Swyddfa Archwilio Cymru; Rob Powell, Swyddfa Archwilio Cymru.

Eraill yn bresennol: Alison Gerrard, Cyfarwyddwr Cyllid, Bwrdd Iechyd Lleol Caerdydd; Gren Kershaw, Prif Weithredwr, Ymddiriedolaeth GIG Conwy a Sir Ddinbych; Siân Richards, Prif Weithredwr, Bwrdd Iechyd Lleol Caerdydd.

Gwasanaeth Pwyllgor: Kathryn Jenkins, Clerc; Ruth Hatton, Dirprwy Glerc.

Assembly Members in attendance: Janet Davies (Chair), Leighton Andrews, Mick Bates, Alun Cairns, Jocelyn Davies, Mark Isherwood, Irene James, Denise Idris Jones, Carl Sargeant, Catherine Thomas.

Officials in attendance: Gillian Body, Wales Audit Office; Jeremy Colman, Auditor General for Wales; Paul Dimblebee, Wales Audit Office; Ian Gibson, Deputy Compliance Officer, National Assembly for Wales; Ann Lloyd, Head of Health and Social Care Department; Elaine Matthews, Wales Audit Office; Rob Powell, Wales Audit Office.

Others in attendance: Alison Gerrard, Director of Finance, Cardiff Local Health Board; Gren Kershaw, Chief Executive, Conwy and Denbighshire NHS Trust; Siân Richards, Chief Executive, Cardiff Local Health Board.

Committee Service: Kathryn Jenkins, Clerk; Ruth Hatton, Deputy Clerk.

*Dechreuodd y cyfarfod am 9.31 a.m.
The meeting began at 9.31 a.m.*

Cyflwyniad, Ymddiheuriadau, Dirprwyon a Datgan Buddiannau Introduction, Apologies, Substitutions and Declarations of Interest

Janet Davies: I start by welcoming members of the public, Wales Audit Office staff and committee members to this meeting. Before I turn to the agenda, I would like to outline some housekeeping issues. Many of you will know that the committee operates bilingually, and the headsets can be used to listen to a translation of Welsh contributions and to hear the whole proceedings more clearly. Will everyone please turn off mobile phones, pagers, and all other electronic devices because, in this building, they interfere with the broadcasting and translation systems? In the case of an emergency, leave by the nearest exit, and the ushers will help you to find your way out.

We have not received any apologies for today, except that Alun Cairns will be late

arriving because he is at another committee meeting first thing this morning. Do any Members have any declarations of interest to make?

Denise Idris Jones: I just want to mention that I am the Assembly Member for the constituency of Conwy, given that we have Mr Gren Kershaw here today, who is the chief executive of Conwy and Denbighshire NHS Trust, but I do not think that that is really a declaration of interest.

Janet Davies: I do not think that, formally, it is a declaration of interest, but thank you, Denise. I ask for the witnesses to be brought in for the next item.

9.34 a.m.

Gwarchod Staff Ymddiriedolaethau'r GIG rhag Trais ac Ymosodiadau Protecting NHS Trust Staff from Violence and Aggression

[1] **Janet Davies:** This item concerns the important issue of protecting NHS trust staff from violence and aggression. I think that it is totally unacceptable that nurses, doctors and support staff suffer from assaults, threats and abusive language from the very people whom they are there to care for. In this session, we will look at the extent of the problem and the adequacy of the steps taken by the Welsh Assembly Government and NHS trusts to protect staff. Today, we are taking evidence from two witnesses, and I ask you to introduce yourselves, please.

Ms Lloyd: I am Ann Lloyd, the head of the Health and Social Care Department for the Welsh Assembly Government and the chief executive of the NHS in Wales.

Mr Kershaw: I am Gren Kershaw, the chief executive of Conwy and Denbighshire NHS Trust.

[2] **Janet Davies:** Welcome to the meeting. I will ask the first questions, which are fairly general, and then other committee members will ask their questions after that. To start, I refer you to paragraphs 1.8, 1.11 and 1.12 in the report, which rather generally highlight the extent of the problem of violence and aggression. Mrs Lloyd, the NHS staff reported 22 incidents of violence and aggression, on average, each day. Why do think that that rate is so high?

Ms Lloyd: I think that it is very much a matter of the type of care that we have to provide and the kinds of people who come in to receive care and attention from us. It says quite clearly in the report—and, unfortunately, it is a familiar picture—that we deal with people who have serious mental health problems, people who might be confused, people who are anxious and who get very stressed in an alien environment, such as a hospital might present. Therefore, the incidence of violence and aggression, even verbal aggression, becomes much more concentrated and higher in our environments than in general society. Much has been done, and the health service is very sensitive to the whole issue of protecting its staff, as it is obliged to do under law. A lot of work has been done to try to ensure that the risk presented by patients or by environments is thoroughly assessed and that action is taken to train staff and, where possible, to amend the environment to reduce the amount of violence and aggression that our staff see. However, I concur with you, Chairman, that it is entirely

and absolutely unacceptable that our staff are subjected to this sort of behaviour when they are trying to help people.

[3] **Janet Davies:** Thank you, Mrs Lloyd. One thing struck me when I was reading the report: some people cannot help being aggressive; any one of us coming round from a general anaesthetic might lash out, as I think the report says. That is one example, and another is people who are mentally ill. Is any differentiation made between that type of violence and aggression, and people who come in to an accident and emergency department having overindulged, for example, in alcohol and drugs and who become violent?

Ms Lloyd: The systems are too unsophisticated at the moment for us to be able to present data to you on that matter, but we do look very carefully at where the incidents have occurred. You are quite right that they include people who are coming round from anaesthetic who will react, and we really have to base our assumptions on where and at what time the incident takes place. We all know that, at weekends, the incidence of violence in accident and emergency departments escalates, and most trusts have done fairly extensive surveys with the Health and Safety Executive on where incidents are likely to arise. It is interesting but unfortunate to note the rise in violent incidents or at least some aggression on medical wards as well, but there is a problem with the rise in dementia among the patients we see. Part of the risk assessment is whether the incident is avoidable. In other words, are people coming in drunk or under the influence of drugs, and therefore need to be managed in a certain way, or are the incidents almost unconscious to the person who is aggressive? Then comes the question of how you manage that sort of person.

[4] **Janet Davies:** Thank you. Mr Kershaw, we note in the report that the rates of violence are quite high in Conwy and Denbighshire NHS Trust. Do you think that there is a particular reason for that?

Mr Kershaw: Yes, I do. Our rates are higher because we have had, for a number of years, a culture of a high level of reporting adverse incidents and incidents of violence against staff. I am pleased to say that, in 2004-05, the figures for violence against staff are indeed falling a little. However, I think that the report acknowledges that the actual numbers do not necessarily tell you what is happening in individual trusts. It is the culture of reporting that is very important.

9.40 a.m.

There is an issue in that some of the statistics include reports on more than one individual. I can say that, on our mental health figures in this report, for our acute assessment unit in mental health, 125 reports, of a total of 150, were made about one individual. So, the figures in the report do not quite paint the picture of whether trusts are dealing with the problem effectively.

[5] **Jocelyn Davies:** On page 20 of the report, the Royal College of Psychiatrists has listed eight factors that influence violence in mental health settings; 23 per cent of attacks take place in those settings. Do you agree that a good many of the listed factors could be avoided, including high levels of boredom, client mix and overcrowding, and unsafe environments?

Ms Lloyd: These are very familiar reasons. Any one of us who has managed mental health services, particularly in the acute sector of mental health, will recognise that these are the kinds of risk assessment factors that one would take into consideration when trying to design new wards or adapt existing wards, because we see quite a wide mix of patients coming into the acute mental health sector. Sometimes, one will have patients who are not only acutely mentally ill but who have substance misuse problems or a more forensic type of mental health problem. Given the types of patients who will mix on a ward, the risk assessment will include all these factors.

As for unsafe environments, as you know, there has been a very large investment in mental health new construction throughout Wales over the past five years, to ensure that the environments are safe. We are constantly looking at the design of the environments. For example, in the North East Wales NHS Trust, although its assessment unit is newish—about seven years old—it was reported to me by the chair and the chief executive that their latest assessment risk assessment led them to believe that their acute ward still presented risks, which is why we have now provided the trust with additional resources to make it a safer place.

Inadequate staffing is always a challenge for us. There are a number of schemes whereby one can assess the numbers and types of staff that are required to manage particular types of patients, which is why you hear of specialising and so on, to try to reduce the possible incidents of violence and aggression. The work done by the Royal College of Psychiatrists is being built into our passport scheme, so that the risk assessment will become more refined, and so that people will begin to address the factors that cause the escalation of violence on wards in a more structured way.

[6] **Jocelyn Davies:** On unsafe environments, it is good to hear that investment is going in to change the situation, but it says in the document that

‘many of the wards and units surveyed failed to meet basic safety standards’.

Ms Lloyd: That is throughout the UK, of course.

[7] **Jocelyn Davies:** What kind of percentage would apply to Wales, and when do you envisage that we will have safe environments, because unsafe environments are causing uncomfortable temperatures and excessive noise, which lead to violence? When do you envisage that we will be satisfied that the environment that we provide in Wales—and people do not have a choice about the environment in which they are working or are treated—will be put right?

Ms Lloyd: In reviewing our mental health facilities, it became clear that the Cardiff facilities desperately need updating, which is why there is an outline business case for those. Elsewhere, there are one or two facilities where action must be taken to improve the accommodation to reduce the risk outlined in the report. We are working all the time with the trusts to try to ensure that the environment improves. The biggest problem remains in Cardiff and in a few of the facilities in Gwent, but I know that Gwent has taken additional action to try to tackle that.

[8] **Jocelyn Davies:** So, are you happy with the description ‘many’ applying to

Wales?

Ms Lloyd: You are never satisfied until everything is right, and we do not just stop there, because you have to consistently and continuously improve. However, much work has been done on removing patients from really poor accommodation, such as that in St David's Hospital and elsewhere. Cefn Coed Hospital also needs updating enormously. How we are to do that has been the subject of correspondence and discussion. So, there are isolated areas now in Wales that are in train to have an additional investment.

I know that Powys, as it moves forward with the next stage of its mental health strategy, is looking at the sort of environment that will be needed for the person of the future. We have to build that into the fact that mental health services are changing very dramatically and that the system is becoming far more community orientated. So the number and scale of facilities that will be needed in the future may not be as great as they are now, but we are looking very closely at low-secure forensic provision, which is inadequate in Wales at the moment, and at acute mental health provision, which is inadequate in some parts of Wales at present. Those are very high priorities.

[9] **Jocelyn Davies:** Thank you for that clarification, Mrs Lloyd. Mr Kershaw, you explained that you have to look beyond the figures. As you mentioned, one individual can be responsible for many attacks on staff and, in the area of mental health, it is not as though you can discard that patient because his or her behaviour is aggressive. Do you feel that violence has become an expected—although not accepted—part of work in the NHS?

Mr Kershaw: That is an interesting question. I think that all the staff are very aware that society has changed a little. In respect of patients in mental health services, staff have always understood that it is part and parcel of understanding an individual's problems and what can happen about that. I read these figures with great interest, and the list that you mentioned from the Royal College of Psychiatrists is very sensible. In my trust, we did some benchmarking to double-check whether the expected incidents of violence were more than we should expect, and I do not believe that to be the case. For us, it is an issue of reporting. It is good that staff report issues, however minor, because they get fed into our analysis to see whether we can improve the circumstances in which we treat and care for our patients. Without doubt, some items in that list are correct. We are not a perfect service and we need to concentrate on issues such as staffing levels and environment and so on. Coming back to the question, yes, I think that staff understand and expect that a level of violence will be associated with caring for patients. Some of it is expected as part of patients' disabilities, and some is not.

[10] **Catherine Thomas:** I have several questions. The first few are directed at Ms Lloyd. I want to look at pages 20 and 21, paragraphs 1.19 to 1.20, and at figure 8 on page 18. Here, the problems facing staff based in general medical wards, general surgical wards and accident and emergency departments are set out. I am sure that you would agree that, when violence is reported in the press, it is usually portrayed as being in accident and emergency departments. However, appendix 2 of the Auditor General for Wales's report shows that staff in general medicine experience three times the number of incidents as those in accident and emergency departments. Do you

think that resources for tackling violence and aggression are being directed to the right places?

9.50 a.m.

Ms Lloyd: Yes, I think so. The staffing levels obviously differ between accident and emergency departments and general medicine wards, including departments caring for elderly. There are many more interventions with individual patients on general medical wards than in accident and emergency departments. Accident and emergency departments get the publicity, but, as these figures clearly show, there is an issue and a problem in the acute medical wards, given the number of elderly and confused patients that are admitted these days.

From personal experience, I believe that staff are also placed in a difficult position because people might get confused because of their illness and unwittingly lash out. Restraining an acute medical patient is quite a sensitive and difficult thing to do because relatives might complain. If you are trying, for example, to do mouth care on a patient who is confused and in pain, they might lash out at you, and yet you know that that work has to be done. There is a very sensitive and fine distinction between trying to ensure that the right care is given to patients and the consequences of relatives possibly misinterpreting your actions, and putting yourself in a position in which you might get hit, so we have to train our staff to manage those very difficult circumstances.

[11] **Catherine Thomas:** Do you feel satisfied with the extent of the training, especially in relation to allowing sufficient time to explain to relatives the situation and the care that is needed and the response to certain situations? Understandably, it is very emotive, and when someone's father or mother is in that situation, perhaps explanations are not always given when they should be.

Ms Lloyd: I think that that is quite true. It is a matter of finding a balance. My view is that you can never give enough training. One of the key issues arising from the report is the help that can be given to staff to deal with these circumstances. They receive training, but every case might be different, and the reactions of relatives might also be different. As part of general patient care, effective communication with relatives is absolutely critical, so that a rapport is developed. However, I think that we just have to be mindful that staff, in certain circumstances, will need additional support when such incidents occur, in dealing with the patients and their relatives, if necessary.

[12] **Catherine Thomas:** Tied into that, referring again to paragraph 1.20, which highlights the risk of violence from elderly mentally infirm patients, with particular risks associated with delayed transfers of care, what do you feel that NHS Wales is doing to tackle the risk of violence from such patients who are delayed unnecessarily on medical wards?

Ms Lloyd: First, we are trying to stop the delays occurring. I think that a lot of good work has been done on reducing the numbers of delayed transfers of care throughout Wales; you have all seen the statistics showing that the number of delayed patients is declining. However, a lot of work still needs to be undertaken with our partners in local government to ensure that there is a smooth transfer of care at an appropriate

time. So, we are trying to tackle the cause of the problem.

Secondly, if you are delayed in hospital, it is not the ideal environment for you. I think that a considerable amount of frustration is felt by individuals who are delayed, because they are not able to move on. They can become institutionalised. Staff are well aware of that, and therefore the risk assessment for such patients will be slightly different and will take into consideration the mental state that can occur when patients are delayed when being transferred. So, those sort of things form part of the training programme that staff receive. However, it is difficult. We have a lot of staff working on a lot of wards where there are a lot of delayed transfers of care.

Again, the ward manager is there to provide a continuity of care and service to all patients, and it is one of the ward manager's responsibilities to ensure that the right risk assessment takes place on the ward and that the right support is given to the whole team of staff.

[13] **Catherine Thomas:** Moving on to paragraph 1.28 and figure 13 on page 25, there is an estimate of the cost of violence, which comes to £6.3 million. Just under £4 million of that represents the cost of providing training and security to protect staff. The remaining £2 million represents the cost of legal cases taken by staff against their employer after incidents have occurred. How can NHS Wales reduce the cost of violence—for example, reducing the substantial costs of settling legal claims—without jeopardising crucial support for staff?

Ms Lloyd: My issue with this is where the money is spent. It might be perfectly reasonable to spend this amount of money on managing these sorts of situations in the NHS in Wales, but I would prefer to see more being spent on the training of staff and their security than on legal cases and staff replacement costs because that, to me, represents a failure, if one can call it that. I would not question the figure, but I would like to see it being spent in different areas. I think that we have to achieve that. The whole principle behind establishing an all-Wales passport scheme and emphasising the requirement for training and development and the support networks that are available for staff in managing difficult situations, will, I hope, enable us to change the allocation of resources so that more goes into training and so that we lose fewer staff as a result of incidents.

You can never be 100 per cent safe, however good an organisation is. There will always be incidents that even the police will advise us could not have been avoided, but you must try to avoid the majority of incidents. So, I hope that the passport, as it is being implemented, will allow us to see a change in the allocation of these resources, so that more goes to preventative measures to protect our staff more, and so that we do not have to pay staff replacement costs or legal fees.

[14] **Catherine Thomas:** Finally, I will ask Mr Kershaw two questions. Moving to paragraph 1.27, almost half of trusts believe that violence and aggression affect the recruitment and retention of staff. Is this a problem for your trust and, if so, what are you doing to address it? Furthermore, do you feel that staff shortages or problems in recruiting and retaining staff increase the risk of violence against remaining staff?

Mr Kershaw: The answer to the first question is that I do not believe that issues of

violence to staff in my trust have affected recruitment and retention. From evidence from the exit interviews that we conduct with our staff, I do not believe that this is a factor. We do not believe that it is a key issue for us. To refer partly to an earlier question that you asked, I also believe that effective dialogue with staff groups is very important to get them to be able to voice their feelings about this issue. In my trust, I meet those staff formally through our health and safety committee to ensure that violent behaviour towards them is not a key issue. I have never heard anecdotally anyone mention that violence in the trust would deter staff from working in particular areas or coming into the trust.

Sorry, what was the second question again?

[15] **Catherine Thomas:** It was in relation to staff shortages or problems with recruiting and retaining staff. Do you feel that that increases the risk of violence against remaining staff?

Mr Kershaw: I have no evidence on that. As most trusts do, we have some areas for which it is more difficult to recruit than others, but there is no evidence, as far as I know, that that is to do with issues associated with violence.

10.00 a.m.

Again, that is based on exit interviews. Where we have shortages, I am not sure that there is evidence to suggest that we get more violence on those wards. I can understand the logic behind that, but I am not aware of it. If, through analysis of the statistics that we get from individual areas such as mental health, it became known to us that staff shortages were related to an increase in violence on the ward, then we would do something about that.

[16] **Catherine Thomas:** I would like to ask about the exit interviews. Does every member of staff have an exit interview?

Mr Kershaw: The policy in the trust is that every member of staff has an exit interview. It is fair to say that compliance with that policy is not 100 per cent. Trade unions have worked with us on this over the past two years—it is a key issue—to make sure that exit interviews are completed. It is just that when staff leave, they do not normally see completing an exit form as their main priority. We have been thinking of ways and means to get them to do that through, for example, their last payroll cheque. However, we are increasing compliance with exit interviews, and the evidence that we get does not suggest to us that violence is a key component.

[17] **Catherine Thomas:** What is the percentage?

Mr Kershaw: It is about 60 per cent.

[18] **Catherine Thomas:** So quite a number of people are not being interviewed. How thorough are the interviews that take place?

Mr Kershaw: They are done through questionnaires. If there was something in a questionnaire that came back to a manager that we felt was critical, then we would

follow that up. It has not been reported to me that issues of violence are a key theme coming through at exit interviews. Also, that has not been raised as a big issue when I have met the trade unions and staff. In our last annual health and safety meeting, where presentations are given every year on key issues, violence against staff was not one of those key issues. However, the year before, we had a presentation on violence and potential violence against staff. We keep it fairly high on the agenda, but, for my trust, I do not believe that it is a key issue in terms of recruitment and retention.

[19] **Mick Bates:** My first question is for Ann Lloyd. Turning to paragraphs 1.30 to 1.35, how confident are you that you now have a full understanding of the extent of violence and aggression in NHS trusts?

Ms Lloyd: I do not think that we are there yet. We have done a lot of work to improve reporting, and a standard definition is now being used in the passport scheme, but there will be people who will not report incidents. It says in the report, and I agree with it, that some people believe that there is no point reporting incidents as nothing will happen. They may also regard it as a one-off and not an ongoing problem. With the number of forms that staff are asked to fill in, it could be seen as just another form—as bureaucracy gone mad. However, this is really important, and we have to get to grips with the numbers and the causes of violence and aggression against our staff.

So we are not there yet, but the passport, and the way that staff and their representatives and the trusts implement it, will, I hope, cause us to improve the understanding of violence and to share good practice. I know that one of our trusts is looking at electronic reporting, but it might be easier for nurses on wards to fill in a form than to take the patient's record off the screen and go into a separate part of the system. We are trying to see what will encourage staff to report more, to ensure that staff are clear about what constitutes an incidence of violence and aggression, and if they particularly suffer from verbal abuse, which many people would ignore or accept as part of the job—

[20] **Mick Bates:** Like politicians.

Ms Lloyd: I could not possibly comment.

It could be seen as part of the job and not important. However, it is important.

[21] **Mick Bates:** I agree; but, in other words, we do not really have an idea if the violence and aggression is getting worse or if there is less of it.

Ms Lloyd: The statistics, which have improved, show that it is falling. The numbers of incidents reported this year have fallen—not enough, but they are falling and going in the right direction. There is a heightened awareness among staff about the necessity to report violence or aggression against them. I think that that is quite a good sign. With the increased training that has been provided, the heightened awareness and the fact that the staff side is very much working in partnership with management to improve the situation in organisations, you would expect them to be rising, but they are not. The schemes that many trusts, such as Gren's, have implemented with regard to carding patients, ensuring that standards are adhered to, and telling patients when

their behaviour is not acceptable, are starting to work. The whole risk assessment of environments in which people are working is starting to reduce the numbers.

[22] **Mick Bates:** Nevertheless, you are not confident that you are getting the full picture.

Ms Lloyd: No.

[23] **Mick Bates:** But the statistics show a decrease.

Ms Lloyd: Yes.

[24] **Mick Bates:** One of the issues that I would take up is data collection. From these paragraphs, it is quite clear that there is no consistent method for collecting data.

Ms Lloyd: That is correct.

[25] **Mick Bates:** What are you doing to address that so that you can have some confidence that you have a full understanding of violence and aggression in the trusts?

Ms Lloyd: We have refined the definition, which was important. The definition is now being applied. How staff interpret it is a matter of the training that goes underneath it, but we are trying to eradicate the areas where we were tripping up in terms of an understanding of this major problem.

The new reporting systems are now in and we are rolling forward with the first year of that. I am still concerned that, when you consider the reasons why people are off sick and for what purposes, we do not currently have a sufficiently good system for reporting that. No doubt you will come back to that.

With the close working relationship that exists between my team, the Minister's team in the Assembly, the trusts and the staff side about tackling this problem, we are gradually trying to close all the loopholes. Trusts spend a lot of time in induction trying to ensure that new or different recruits or agency staff who come to work for them understand the importance of health and safety in that environment. As it says in the document, junior doctors are not too good at reporting it—mind you, they are not with the patients quite as much as the nurses are—but the induction programmes are trying to address all of the groups that might decide that it is a part of the job and that they do not have to report it. We cannot tackle the problem unless we understand the scale of it.

[26] **Mick Bates:** Absolutely; it comes down to the data again. Given that you have this consistency of definition and data collection, how will you centrally monitor and evaluate the statistics that you will have?

Ms Lloyd: We have been doing that consistently. We have never called for these statistics before but we shall be doing so, because the statistics will go into the balanced scorecard so that we get a complete picture of health and safety within organisations. The Welsh risk pool standards for Gren's trust will also go into the balanced scorecard from next year so that we get a more complete picture about the

health and safety of our employees. We just have to work at it.

[27] **Mick Bates:** Mr Kershaw, what can you do to make it easier and worthwhile for your staff to report all incidents of violence and aggression?

Mr Kershaw: First, on the trust's policy, although we use a system that definitely records serious incidents, we have had a culture of reporting all incidents. As Ms Lloyd said, there is an issue around the definition and the interpretation of that definition by staff. If an individual walks into the accident and emergency department and swears at the receptionist, and that is the only thing that happens, is that a recorded incident? The interpretation of the definition is quite difficult. The passport scheme is a very useful way forward to try to ensure that we get that definition. I believe that it is an individual issue for leadership in trusts to ensure that staff report it when they feel that they have personally been abused or threatened. It is for managers to ensure that staff understand that. It is only when we get the data that we can analyse that to see whether we have an underlying problem. While I understand the question that you asked for the whole of Wales, the issue about reducing the incidents of violence and abuse must be tackled locally, in local organisations. I believe that it is a key component of management's responsibility.

10.10 a.m.

[28] **Mick Bates:** Thank you; that is a practical response. However, since you want to collect better data—let us take accident and emergency, for example, where there are fast-moving situations—how do you get that data from situations such as accident and emergency in your trust?

Mr Kershaw: There is an established system in the trust for reporting, through a centrally set form, which is analysed and comes back. That is the fundamental system. However, it is true that, in busy accident and emergency departments, the nurses, while having to meet targets for treating patients, might not always see filling in a form when someone swears at them as being the priority. In my trust, we have a security service—an individual—that operates 24 hours a day. That individual is based in the accident and emergency department in the evening, at times when the department is under stress from people coming in who may have overindulged in alcohol. That individual helps the nurses complete the data on those forms for us, because it is a busy time for nurses in the accident and emergency department. Therefore, that is a practical way in which we get some information about what is happening.

[29] **Jocelyn Davies:** Ms Lloyd, I am sure that you recall that, when the Royal College of Nursing gave evidence to the Health and Social Services Committee, it said that, in some workplaces, the action being taken to protect staff was restricted to putting a poster on the wall telling the public not to assault the staff. Under those circumstances, would you expect staff to report incidents, when the only action that they could see by their employer was a poster saying, 'Do not assault our staff'?

Ms Lloyd: If they do not report it, the management is never going to do anything, because they will not have a basis for making a decision on whether it is a problem. Just putting a poster on the wall hardly seems to be adequate, by any stretch of the

imagination. We have a duty to protect our staff at all times, and there has to be, as Gren said, a clear leadership statement that violence and aggression will not be tolerated, particularly in areas where it might be expected, and is self-inflicted in terms of the person undertaking the violence. Therefore, we have to encourage management to take this seriously, and encourage staff to report it. If management does not get any reports, it might think that putting a poster on the wall is adequate, but it would not, logically, seem so.

[30] **Jocelyn Davies:** If nothing is done to protect the staff, and they are attacked, it can account for us having 60 cases and legal costs of £2 million.

Ms Lloyd: Yes, quite; and for having ruined lives.

[31] **Janet Davies:** Before we go on to section 2, you wanted to come in on something, Carl.

[32] **Carl Sargeant:** Yes. I will pick up on a point on data collection that you were talking about to Mick, just for clarification. I fully understand that it is a matter of the interpretation of definitions, and of how people perceive being abused, or not abused; swearing might be acceptable to some and not to others. Can you clarify that it is the same rules for all trusts now, including the ambulance service?

Ms Lloyd: Yes, it is.

[33] **Carl Sargeant:** Perhaps Mr Kershaw could pick up on the point about North East Wales NHS Trust and Conwy and Denbighshire NHS Trust having different definitions, and why that choice was made.

Mr Kershaw: Until the passport scheme was published this year, targeting many key issues over the next year or so, trusts adopted different definitions. We happened to adopt the definition that was used by the Department of Health in England because it was linked to the considerable amount of work that Ashworth Hospital had done in this respect on defining what an incident was. Therefore, we happened to pick that one up, and it is the one that we have been using, but it would be of no difficulty for us to move through to the passport scheme. When we induct new members of staff and do refresher training for members of staff, we can fold that in. So, I would agree that trying to get to a standard definition and its interpretation is the way in which Wales should go forward.

[34] **Carl Sargeant:** That is all very well, but do you think that the system that we are using now is the right one, given that there were so many out there? Have we moved to the passport system, and is it the right one, or was yours better?

Mr Kershaw: I think that the data here clearly show that trusts have been using different systems; that is a very useful point in the report. The passport scheme, which aims to introduce a single defined way forward, is the way to go.

[35] **Janet Davies:** We will now move on to part 2, beginning with Denise Idris Jones.

[36] **Denise Idris Jones:** I will be looking at the action taken by the Welsh Assembly Government to protect staff from violence and aggression. If we look at paragraph 2.3 on pages 28 and 29 of the report, the last sentence says that

‘an all-Wales approach to violence and intimidation may be set up eventually.’

I am hoping that, having heard what we have heard today, we are aiming towards a zero-tolerance approach. What is your comment on that, Ms Lloyd?

Ms Lloyd: The passport is the beginning of this all-Wales approach to violence and intimidation. So, I do not think that it is an issue of whether it may be set up eventually; the baseline is already there. The passport is being extended and developed as we speak, looking at mental health areas in particular and at some of the Healthcare Commission reports that have been produced recently on the management of violent patients such environments. Fundamental to this has been the fact that, some three or four years ago, we set up an all-Wales working group for staff on health and safety and managing violent incidents, from which the passport has emanated. We are right at the beginning of a scheme where we just will not put up with violence that is intended, and we will manage better the violence that is not intended. As I said, you will never eradicate everything, but you have to do your best.

[37] **Denise Idris Jones:** So, we are working towards a zero-tolerance campaign?

Ms Lloyd: Yes.

[38] **Denise Idris Jones:** Good, I am pleased to hear that. It is nice to see you, Mr Kershaw. Having read the report and knowing the area so well as the Assembly Member for the constituency of Conwy, I was rather surprised to see that we have such a high number of violent incidents in Ysbyty Glan Clwyd. However, when you think about it, it is an area where we have many holidaymakers, in Rhyl, Prestatyn, Abergele and my area of Llandudno. Do you think that this might be a contributing factor to the high number of incidents in Ysbyty Glan Clwyd?

Mr Kershaw: The number of incidents should not be seen, in my view, to reflect that we are in a violent area. I think that the report says that clearly early on. In respect of your second point about whether this could be attributed to holidaymakers, I am not sure that I am in a position to be able to comment on that. It is well known that accident and emergency departments, during the summer months, treat and care for a high number of casualties who are holidaymakers and who get themselves into some difficulties. One can assume that alcohol and maybe even drugs are key components of that, but I have no specific evidence to say that it is holidaymakers.

[39] **Denise Idris Jones:** As a trust chief executive, how do you think the Welsh Assembly Government could better support NHS trusts in protecting NHS staff from violence?

Mr Kershaw: The passport scheme is a way forward, without doubt, and it is, as we said, about trying to get some standardisation into definitions about the nature of the problem. An agreed training programme for staff is also a very important component. All chief executives in Wales should acknowledge the report and ensure that they

explain clearly to staff the nature of the problem. I am pleased that that is happening. The Welsh risk pool has a role, and I am happy to answer further questions on that.

10.20 a.m.

[40] **Denise Idris Jones:** Do most of the problems occur at night?

Mr Kershaw: There are a considerable number of problems late at night in accident and emergency departments. However, violence can happen during the day, especially in the area where it is difficult to differentiate between someone who is ill and who may consequentially be violent, and someone who is just plainly violent and abusive. Neither the data in the report nor the data that we routinely collect would identify that problem specifically. On a practical level, in my trust, the fact that we put a security guard in the accident and emergency department at night acknowledges that there may be an issue. It is a fairly practical solution.

[41] **Denise Idris Jones:** That is worth thinking about.

[42] **Jocelyn Davies:** Are there more violent attacks in the summer months?

Mr Kershaw: I do not have any data on that, but I would suspect that, because of the increase in numbers of accident and emergency attendees in summer months, consequently the reported violence may also increase. I am happy to supply the committee with some information on that.

[43] **Mark Isherwood:** I want to look at paragraphs 2.8 and 2.9 and the targets set by the Welsh Assembly Government in 2001 for trusts to reduce the number of incidents by 10 per cent by 2004, but without any baseline against which to measure progress. I note concerns raised by the auditor general that the service and financial framework target could be a perverse incentive by discouraging the reporting of incidents. I also note that the new performance improvement framework for trusts does not mention violence at all. Therefore, has the Welsh Assembly Government put the right emphasis on tackling violence against staff? Please provide evidence for your conclusion.

Ms Lloyd: Yes, of course it has. We would not have included in the service and financial framework targets an indicator to reduce violence had we not felt that there was a necessity to improve the recording and management of violence. A lot of guidance has been produced by the Welsh Assembly Government on the importance of tackling violence and aggression against staff. That guidance has culminated in the passport and, more recently, the security framework. For example, lone worker schemes and accompanying alarm systems are being developed. The Welsh Assembly Government has done a lot of work and placed a great deal of emphasis on managing health and safety, with the Health and Safety Executive, with regard to managing violence.

The auditor general said that the Welsh Assembly Government was right to abandon quantitative targets. Those were established in the first place largely as a result of the recommendations of the HSE in its 'Revitalising Health and Safety' strategy. Because we were concerned about the health and wellbeing of staff, the Minister decided that a

target should be included in the service and financial framework to reduce the incidence of violence. One problem with that, as you said, was that it could lead to perversity in terms of recording incidents. However, the recording systems at the time were insufficient to be able to adjudge what had happened. This is not the only target for which that was the case. Therefore, we took advice and retained a theme of improving health and safety for our employees in the balanced scorecard. As I said before, this will be extended this coming year to include the data on health and safety, violence and aggression, and the Welsh risk pool standard outcomes, so that there will still be an open and transparent way in which the communities and the staff can adjudge how well their organisation is performing on these important themes.

[44] **Mark Isherwood:** Mr Kershaw, do you feel appropriately incentivised to report accurately? Do you feel that any perversity has been removed from the system?

Mr Kershaw: I accept the report's view that targeting this area may cause trusts to think through how they report. Personally, I do not think that it is an area that lends itself easily to targeted performance, largely because of all that we have said before about the lack of conciseness about the definitional terms. I would run with what Mrs Lloyd has said, which is that, through the performance management of trusts, we need to ensure that the leaders of organisations have this sufficiently high on their agenda, and have local systems in place so that they can monitor what is happening in their own organisations.

[45] **Mark Isherwood:** Moving on from that, paragraphs 2.10 to 2.12 describe the Welsh risk pool management standards, and we understand that Conwy and Denbighshire NHS Trust manages the Welsh risk pool, as I think you mentioned a short while ago. Can you tell us about the way that the Welsh risk pool supports trusts in protecting staff against violence?

Mr Kershaw: I am wearing a slightly different hat now as accounting officer for the Welsh risk pool. Paragraph 2.10 clearly describes the role of the Welsh risk pool. There is a set of standards, developed with NHS Wales, that contains all our legal and regulatory obligations and the desires of the Assembly in terms of what we should do, against which we assess organisations annually. Not all of the 40 standards are assessed by the Welsh risk pool; some come under another heading of 'controls assurance', and require self-assessment by organisations. The security standard, for example, is one that is assessed by organisations themselves. However, most of the other areas that we have been talking about, such as issues in mental health, in community working and in accident and emergency, are contained in standards assessed annually by the Welsh risk pool.

The results of those assessments are given to Mrs Lloyd, reporting compliance with a standard. All those reports are fed back to individual organisations, so an organisation will get its own report and a report of the performance across Wales. While we have not been able to do a specific report on violence, we understand how high-profile this issue is, and, during the course of one of the assessments that we did this year, we looked at night-time security in trusts, and have fed back to individual organisations how we feel that they have performed in night security. From memory, the figures showed that five trusts that did very well, one trust did not do quite so well, and the rest were in the middle. We went back to the trust that we had some concerns about to

explain what those concerns were.

In summary, the Welsh risk pool feeds the compliance back to individual organisations and to Mrs Lloyd for the performance management of the NHS. We help by giving individual supportive reports back to individual trusts.

[46] **Mark Isherwood:** I note that. Nonetheless, Mrs Lloyd, paragraph 2.11 reports that a minority of organisations is still failing to meet the required risk management standards. Is this putting staff at risk, and what are you doing about it?

Ms Lloyd: Let me put that in context: the standard set was one of 75 per cent. As you rightly say, three trusts just failed to meet that—some by 1 per cent. However, the important thing was that although they had this discussion with the Welsh risk pool—which will form part of their performance management and which is undertaken by the regional officers of the Welsh Assembly Government—they all met their core standards, which were about risk-management systems, risk profiles, adverse incident and hazard reporting, communication, consent to treatment, audit and supervision. The really core standards were met by those organisations at the required standard. Nevertheless, my regional officers will have been notified of any trust that failed to meet a Welsh risk pool standard, and that will form part of performance management this year, to ensure that trusts meet the standards that are being met elsewhere in Wales. The percentage is ratcheted up every year.

10.30 a.m.

[47] **Irene James:** Turning to pages 30 and 31 of the document, paragraphs 2.6 to 2.29, paragraph 2.6 states that the passport has significantly improved the risk management framework. It goes on to say that trusts are having problems releasing staff for training and covering their duties. Mrs Lloyd, what progress have NHS trusts made in implementing the passport scheme?

Ms Lloyd: We are due to receive a report from all trusts, by the end of March 2006, on how they are implementing the passport scheme, which includes a training assessment. Some reports have already come in because the training assessments of staff have been completed by some trusts. The implementation of approved training at the required quantity and quality is starting now. Some are reporting that they will not have completed the training until 2008. Therefore my staff are discussing with them, and with the regional co-ordinating group of health and safety officers in all trusts, how we might ensure that early training is targeted at those who are most at risk. The rest of the training can be rolled out later. They must also try to improve the timescale in which training is to be provided.

As with all training in the health service, this is a constant problem. With 'Agenda for Change' and the new consultants' contract, it has been addressed in terms of providing sufficient time for training to be undertaken, particularly for health and safety issues such as manual handling, for which, again, there is a passport scheme, and violence and aggression. We are working closely with the trusts to ensure that they will be compliant with the passport standards and that they are going to adequately and appropriately train their staff, as is required of them by law.

[48] **Irene James:** Do you think that there is any more that trusts could do to speed up this process and to smooth out any problems? Ultimately, it is the staff that are at the end of it and if they do not receive appropriate training, they will not be able to help themselves and the rest of us.

Ms Lloyd: The safety and protection of staff is a legal obligation on all NHS employers, as it is for other employers. Improving the management of violence and aggression in NHS trusts in Wales is highly important. They will be performance-managed against it, they have to comply with the passport and tell us how they are going to do so by March, and we are rolling out other schemes to help them to better protect their staff. As it is such a fundamental part of the performance quadrant on managing and improving staff in the health service, they are going to be constantly monitored on this—not in a punitive way, but in a way that facilitates their ability to train their staff to an adequate standard. We can help and facilitate through good policy making, providing information to organisations on the staff side, and through offering good training packages, and that is what we are trying to do.

[49] **Irene James:** Mr Kershaw, what impact has the passport had on your trust?

Mr Kershaw: I think that it is fair to say that we, as an organisation, were making some good inroads in the direction that the passport was going in any case, particularly with regard to training—more than 600 of our staff are trained in some of the issues associated with violence—and the different types of training programmes that go with that. I have to say that it is a very real problem finding time for busy staff on wards to do what we now clump together as mandatory training. It is not just in this area; it is also, as Mrs Lloyd said, in manual handling, resuscitation training, consent and so on.

In fact, the requirement to adequately train staff now means that we are pulling quite a lot of individuals away from ward work. We now have to consider different ways of providing that training, which can range from training a week before staff start their employment or their duties. These are not agreed yet, but they are different ways of going about the problem. There are issues about e-learning that we have to take up a great deal more. I certainly believe that staff do not need teaching in a classroom to get to grips with a number of the issues in this regard, and we need to get smarter and use electronic training in different ways. If we do not use some of these new initiatives, because of the requirements by regulation or law for mandatory training, we will have more staff off the wards than we have on them. So, we really have to change the way in which we do some of this stuff.

[50] **Janet Davies:** Thank you. Mark, you are under a heavy burden this morning.

[51] **Mark Isherwood:** Not at all; they are my own questions.

Jumping now to paragraphs 2.33 to 2.34, they refer to the fact that, in addition to assessing risk, proportionate action must be taken to manage those risks identified. They look at what trusts have done to improve the design of the working environment to act on those assessed risks and minimise the likelihood of them occurring. Going backwards, however, paragraph 2.26 identifies the fact that Conwy and Denbighshire trust did not carry out generic risk assessments of buildings unless something was

specifically remiss, although you assess mental health patients on admission, as I think you have already told us. Mr Kershaw, to what extent do you think that design issues and the provision of alarm systems protect the staff in your trust, or do you believe that the working practices, systems and training are sufficient?

Mr Kershaw: We referred earlier to the Royal College of Psychiatrists' view that design of the environment is a really important issue, and that was obviously true for mental health patients. I agree; design is an issue. In my trust, however, we operate out of 60 premises, as well as the district general hospital, which is a very complex building. We have taken the view that looking at the environment and risk-assessing every part of it might not be good value in terms of undertaking risk assessments, and we have taken the view that we should risk-assess those areas that we really, truly know to be problem areas, and risk-assess individual patients.

In terms of the environment, we have done some work, for example, on our accident and emergency department, as we knew that the reception area was not conducive to helping patients to behave—if that is the right way to express it. In our mental health unit, we know that we have a problem in the intensive care end, and we have to do some redesigning. So, I do not disagree that, in an ideal world, we should risk-assess the environment; it is just that, on a personal basis, it is probably not as much of a priority as is dealing with those areas in which we know that there are problems.

With regard to alert systems and alarms, I absolutely believe that we should provide the vulnerable staff to which I referred, such as lone workers, with all the technology that helps them to stay safe. The use of mobile phones is very standard practice for lone workers in my trust, but that is not perfect because of cell coverage, so there are different solutions for different areas. Although I cannot disagree that the environment is an important issue, my personal view is that we should give close attention to the areas in which we know that we have problems.

10.40 a.m.

[52] **Mark Isherwood:** Thank you for that. Having visited many of your premises, I understand your comments about the wide distribution of your property stock. Nonetheless, I refer back to paragraph 2.33, which says that

‘Often such actions carry low or no cost’.

Not all actions will, but many will. Are you satisfied that your risk assessments, in relation to buildings and premises, are sufficient, or do you feel that more could be done to routinely risk-assess your building?

Mr Kershaw: In an ideal world, the answer is that, yes, we should do more risk assessment, but I am satisfied, as chief executive, that we are concentrating on the correct areas. We can always do better, but I am quite satisfied. The particular areas on which we have concentrated are closed circuit and digital television, and we have invested enormous amounts of money on the Ysbyty Glan Clwyd side over the last couple of years to ensure that we have average coverage there. So, there is a resource issue—I must put the money in the areas in which my professional managers and I think are a priority.

[53] **Mark Isherwood:** Other than the issues that you have raised about the type and spread of property, what other problems do you experience, if any, in implementing the actions identified through the risk assessments carried out by your trust? I will refer to a specific problem. I started the meeting naively assuming that most violence or aggression would be carried out by younger or middle-aged people, but I have heard from your evidence that it often relates to elderly and disturbed people, or to people affected by delayed transfers of care. I also note that Conwy and Denbighshire trust has the highest proportion of older people in Wales. How do the resources recognise the demographics of your patient base, and how does it reflect the particular risks associated with the age groups that you serve?

Mr Kershaw: I cannot remember any specific resource being prioritised for elderly groups, despite the fact that we have a large elderly population. I do not know whether we have done any work around that area.

[54] **Mark Isherwood:** Have you done any work at a national level around that area?

Ms Lloyd: No, because the outcomes of risk assessments in each area will be different, and it will be for the leadership within the organisation to channel resources and efforts to those areas that represent the greatest risk to staff. I concur with Mr Kershaw's view about a practical approach to risk assessment and the management of the environment, because, speaking as a former trust chief executive, that is what we had to do; we had to ensure that we channelled our resources and efforts into those areas that we knew would be a problem, owing to the nature of the illnesses suffered by individuals, while keeping a general risk assessment environment throughout the rest of the organisation.

[55] **Carl Sargeant:** I refer to paragraph 2.40 and 2.41, regarding working with the police. One of the issues in the table in figure 22 suggests that four of the trusts believed that the response by the police was either fairly satisfactory or very unsatisfactory. What have you or the trusts done about that? Have the trusts formalised a complaint to the police regarding this unsatisfactory response?

Ms Lloyd: I did not know that this was the trusts' opinion until I read the report. So, I have asked my officials to take it up with the organisations concerned. It could be down to what expectations the organisations have of the intervention action that the police can take. It could also be a question of what the trust itself is doing about security, and the kind of discussions that the trusts have held with the police about the types of incidents where they might have to call the police, when they have a situation in which they feel unable to control themselves.

It seems to me as though there is a lack of communication here, and that the two parties do not really understand what the expectations of each other might be. In my trust, we work very successfully with the police over all of our general hospital sites, but then we put an enormous amount of effort into working with community partners and ensuring that security was high in those areas of Bristol where you might expect a particularly high incidence of violence and aggression. We, as two parties, understood what was expected of each other. I would suggest, and my staff are following this up, that there might be a misunderstanding and a breakdown of communications between

the parties concerned.

[56] **Carl Sargeant:** I wonder whether it would be reasonable, Chair, to ask Mrs Lloyd to follow that up with a note regarding what is happening and the outcomes. That breakdown of communication is quite concerning. On that, Mr Kershaw, could you tell us how effectively your trust works with the local police force to protect staff, and how joint working could improve?

Mr Kershaw: Before we get to the police, we have a system in place that is called the 'contract of care', which is a formal policy. To put it more simply, it is a yellow card/red card system that we operate, so, before we get to dealing with police issues, we deal with the individual patients.

The relationship with the police on my patch is excellent to the point where we now have a local constable who is based for approximately 50 per cent of his time in the hospital and can easily be called upon because he works in the local vicinity. Our accident and emergency staff have a very positive and constructive relationship with the police. I, personally, have not become involved in that relationship. I have not found the need to contact anybody senior in the police force, but my managers have relationships with individuals through other initiatives, so, for example, my director of operations is involved in major accident planning and I suspect that the relationships with the local constabulary are formed through issues that are not just related to this issue. I am sorry, but that is the only way in which I can help you. It feels very positive on my particular patch.

[57] **Carl Sargeant:** Mrs Lloyd, do you have any views on that and on how the Assembly Government could support the NHS and working practices with the police?

Ms Lloyd: We are encouraging the full participation of the health service and social care in the community partnerships that are developing throughout Wales. It has to be very much managed at a local level so that we can outline best practice and provide the encouragement to understand the benefit that will emerge from good community partnership working, which has been very successful in many parts of Wales.

[58] **Leighton Andrews:** My questions are about repeat offenders. Mr Kershaw, at the beginning of this session, you drew attention to the fact that some of the statistics were high because there were quite regular repeat offenders. How do you, in your trust, ensure that all staff are aware of whether a service user or visitor is a persistent offender, and do you think that the arrangements that you have in place are adequate to protect you?

Mr Kershaw: I am not sure whether I would use the word 'offender' in relation to a patient whose illness results in violence. Staff would feel that the patient to whom I referred who had 125 reports is ill. That patient is well known to the staff who treat them. We have another individual out in the community who also has mental health issues, and lots of reports come in on that individual.

10.50 a.m.

Within the general body of the hospital, patients who are offenders or who are violent

would be noted on incident report forms, and we would be able to check whether an individual patient, even if he or she entered a different part of the health service, was responsible for offending. So, we could track them through. I know of one patient for whom that has happened.

I know that, in some trusts, their patient administration computer systems are able to tag individuals if an offence has been committed. We do not do that in my trust, but we keep good manual records. If someone offends on a number of occasions, or the offence is very serious, we will move to what I referred to a few minutes ago, that is, our contracts of care, which are yellow cards and red cards. Since that scheme, which was launched by the Minister a few years ago, came into operation, we have issued five yellow cards and one red card.

[59] **Leighton Andrews:** I am particularly interested in how those things are communicated to the rest of the staff.

Mr Kershaw: I do not believe that we routinely circulate the names of individuals who have committed an offence, or who are yellow-card offenders. I happen to know that the one red-card offender, who is a very difficult and complex individual—and there is an issue about whether his behaviour is an illness or an offence—is well known to the staff and the security people involved. If that individual comes into our organisation, we can identify that pretty quickly. Many of the incidents relate to one individual on one occasion, so it would not be appropriate to circulate those names more widely throughout the organisation.

[60] **Leighton Andrews:** Mrs Lloyd, do you think that trusts have the right measures in place to deal with people who persistently cause trouble?

Ms Lloyd: Guidance is contained in the passport on how you might manage this. The new security framework also provides examples of best practice. As part of our monitoring of the implementation of that passport, that will be one of the direct questions that is posed to organisations. It is difficult. There is a sort of in-built reluctance among staff to report patients because of confidentiality and so on, but, as Gren describes, an escalation process is contained within the guidance, and ways in which we might manage particularly difficult individuals. Again, as he said, these are very isolated cases; it is not something that you would operate for the vast majority of people who commit assaults.

[61] **Leighton Andrews:** The report says that all trusts are looking to the Welsh Assembly Government for guidance on the Human Rights Act 1998 and data protection issues. Is that forthcoming?

Ms Lloyd: It is. We have started it in the passport, but because it is a very sensitive area, we are clarifying at the moment the real rights that will underpin the actions of staff. So, that is being done.

[62] **Leighton Andrews:** Right. Are you confident that you can share information within trusts and with other agencies about persistent offenders?

Mr Kershaw: If somebody is a repeat offender and they come into our card system,

we notify the local general practitioner as well. We have a local policeman on site, and I presume that he will get to know about a carded person as well, though I am not sure. I think that there are difficulties over confidentiality in terms of circulating the name of someone who may have committed one offence. Not all patients or offenders will acknowledge that they have committed an offence. If they are very frustrated or ill or whatever, they might not actually see it in the same way as the staff do.

[63] **Leighton Andrews:** Can you share information with social services departments?

Mr Kershaw: I am sure that we could do that on a confidential basis, but I do not know whether that has been done in practice.

[64] **Jocelyn Davies:** Would you share that information with another trust, because someone could quite easily go to an accident and emergency department in the trust next door? Would you share that information if you felt that an individual was a particular danger?

Mr Kershaw: I would have no difficulty in sharing that with another trust, particularly if someone was likely to try to enter the service there. Indeed, across the NHS, there is an alert system for people who are difficult, for example those with Munchausen syndrome and others. We occasionally get warnings about individuals who are very difficult. My personal view, with respect to the Human Rights Act 1998, is that there is a greater good about ensuring that you safeguard your staff.

[65] **Janet Davies:** Just to finish, I want to ask Mrs Lloyd a question about securing prosecutions where that is appropriate. What is the Assembly doing to support trusts in securing prosecutions?

Ms Lloyd: I think that the problem of prosecution is well-described in this report. It is a problem that the individual has to take out the prosecution at the moment, so we are working with Welsh Health Legal Services to see to what extent an organisation could act on behalf of an individual. It is a tricky area of law, and that is why we are working with our NHS legal services to try to ensure that we can cover all the bases.

I know that AMs are lobbying for attacks on emergency personnel to become a criminal offence. We can do a number of things, and certainly the criminal convictions are quite difficult to secure because of the necessity for the individual to act. If we can, in any way, put some of that responsibility onto the organisation that employs the individual who has had an offence made against them, then I think that that might ease the situation.

If we are serious about zero tolerance, we must be seen to act. Some of the trusts are making use of anti-social behaviour orders. North Glamorgan NHS Trust has started off very well indeed, and it did have particular problems. However, that is a no-shame way of trying to tackle the problem. We must continue to work with organisations to try to secure prosecution as and when appropriate.

[66] **Janet Davies:** Mr Kershaw, is there anything else that you would like from the Assembly Government in terms of securing prosecutions?

Mr Kershaw: I am not aware of any way in which the Assembly can help further on this in relation to my own trust. There have been a small number of prosecutions and the police have been extremely helpful about those. There are some occasions when staff feel exposed in appearing as witnesses in court cases. That should not be underestimated. Staff feel vulnerable about pursuing things. I am not aware of what the Assembly could do further.

Ms Lloyd: We are working with the NHS Counter Fraud and Security Management Service in England to try to overcome the issue of the difficulty of securing prosecutions.

[67] **Janet Davies:** It is very understandable if staff are nervous about this issue. Catherine has one question on this topic.

[68] **Catherine Thomas:** I wanted to ask it right at the end, if there is something else that you would like to ask.

[69] **Janet Davies:** No, there is nothing else.

[70] **Catherine Thomas:** This goes back to the collection and analysis of data. Do you have any information on attacks that are motivated by racism on staff from black and ethnic minority communities? Also, looking at some of the statistics in relation to attacks and incidents against ambulance trust staff, do you have a breakdown of that into attacks on female and male staff? Do you also have an analysis in terms of age, and whether perhaps younger staff are more susceptible than older staff? I was just wondering about the extent of the analysis.

11.00 a.m.

Mr Kershaw: Those are interesting questions. I know that we have some racially-motivated abuse of staff, and not just in accident and emergency departments. We take a predictably tough line on that. I am not aware of any particular age or sex issues associated with violent incidents. There are undoubtedly some racial issues.

[71] **Catherine Thomas:** Would you comment on that, Mrs Lloyd?

Ms Lloyd: The information is imprecise at the moment, but the electronic staff record, which will be coming in now for next year, should be able to help us to drill down into those areas. We are mindful of the discrimination Acts, and their consequences for all forms of the care that we give. It is worth seeing whether there is a possibility of tracking the information and whether it is a serious issue that we need to address.

[72] **Janet Davies:** I will draw this part of the meeting to a close. I thank both Ms Lloyd and Mr Kershaw for their helpful and courteous answers, and for the light that has been shed on what happens in a specific trust. That was very helpful, Mr Kershaw. You will both be sent a draft transcript, which you can check for accuracy, and the transcript will later be published.



Llywodraeth Cynulliad Cymru
Welsh Assembly Government

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Eich cyf / Your ref:
Ein cyf / Our ref: AJL/ FN

28th November 2005

Dear Kathryn,

AUDIT COMMITTEE - 10TH NOVEMBER

I refer to my appearance before the Audit on the 10th November.

You are aware that I agreed to provide further information on how NHS Trusts are working with police to reduce possible breakdowns in communication when attempting to prevent or deal with incidents. After consulting Trusts in Wales it seems that not all Trusts have formal mechanisms in place. What is being arranged is that all Trusts will be required to be part of Community Partnerships where Health, Social Care, the Police, Probation, and other key stakeholders come together. To ensure this happens I have asked officials to liaise with the Welsh Risk Pool to ensure this requirement forms part of one of their risk management standards.

In relation to Gren Kershaw's update information he has provided the following information:

We've looked back over 2003 and 2004. There is no definitive relationship between Summer months and numbers of incidents in A&E to suggest the problem is caused by the influx of holidaymakers. In 2003 52% of the reported incidents in A&E for the full year were recorded in the quarter 1st July to 30th September. However in 2004 only 17% of the reported incidents in A&E were recorded in the summer quarter.

With regard to the second action point on the Out of Hours evidence I attach a copy of Sian Richards paper detailing the methodology for which future contracts should be decided by the Board.



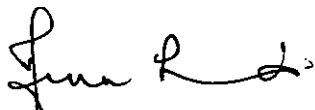
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If you need any further clarification or information please let me know.

Yours sincerely



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