PREVENTION AND MANAGEMENT OF VIOLENCE WHERE WITHDRAWAL OF TREATMENT IS NOT AN OPTION
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EXECUTIVE SUMMARY

The purpose of this document is to provide NHS health bodies in England with a framework for the development of policies, procedures and systems to help protect staff in healthcare environments from non-physical and physical assault where the withdrawal of treatment from patients is not appropriate. The framework may be adapted for local use as appropriate.

Much has been done to address the issue of violence and antisocial behaviour in society today in an effort to create a modern culture of respect – from the introduction of measures such as Anti-Social Behaviour Orders to the cross-government strategy to tackle bad behaviour and nurture good in communities. Violence and antisocial behaviour, regrettably, still exist; particularly concerning is when this behaviour impacts on the delivery of healthcare and those public servants who provide this care.

The government has introduced a comprehensive framework to tackle violence against NHS staff, most notably with the creation of the NHS Security Management Service (NHS SMS) in 2003. As part of its strategy to make the NHS a safer and more secure place to work, the NHS SMS has introduced a number of measures, such as a national reporting system for physical assaults and consistent reporting procedures for non-physical assaults on NHS staff, a legal protection unit to work with the police and Crown Prosecution Service (CPS) and the training of Local Security Management Specialists (LSMSs) in each NHS health body.

However, we recognise that more needs to be done to prevent and manage violence in certain areas of the NHS such as where long-term care is provided and in order to sustain life, withdrawal of treatment is not an option. With the support of the Department’s Chief Nursing Officer, NHS SMS convened a working group to develop this guidance which includes practical measures from a proactive and reactive perspective.

The guidance examines the possible reasons for and risk factors associated with violence. Using a public health model, it describes the steps that can be taken to reduce violence in long-term healthcare environments across the NHS. It discusses a range of measures available to health bodies to tackle the problem and provides practical tools such as a behaviour agreement, warning letter template and assessment tool that may be adapted for local use.

We hope that NHS health bodies across England will find the guidance useful in dealing with this problem locally.
1 AIM

1.1 The aim of this document is to give NHS health bodies a framework for the development or adaptation – as appropriate – of local policies, procedures and systems to help protect staff from physical and non-physical assault, specifically in environments where the withdrawal of treatment is not appropriate. The guidance is intended primarily for staff caring for individuals who have the capacity to take responsibility for their own behaviour.

2 INTRODUCTION

2.1 Work-related violence and aggression is a recognised occupational hazard for staff working in the NHS. NHS staff and professionals are at greater risk of physical assault or verbal abuse than many other professionals. This is underlined by the Department of Health statistics for 2004–2005:

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

2.2 Successive governments have put forward a number of initiatives in an attempt to tackle the issues leading to violence and aggression in the NHS. Most recently, in April 2003, the NHS SMS was launched with the remit of policy and operational responsibility for the management of security in the NHS. The remit is broad but can be defined as protecting people and property in the NHS through the creation of a safe and secure environment, so that the highest standards of clinical care can be made available to patients.

2.3 Since its launch, the NHS SMS has implemented a programme of work and national initiatives to tackle violence in the NHS. These include the launch of the NHS SMS strategy document *A Professional Approach to Managing Security in the NHS* in December 2003 and the introduction of two legal frameworks that take forward work to tackle violence and general security management issues. The first framework, on tackling violence against staff and professionals who work in or provide services to the NHS, details the requirements for:

- concise, consistent, legally-based definitions for staff to report physical and non-physical assaults
- a streamlined national system for the reporting and recording of physical assaults (see appendix 6 for a physical assault reporting system (PARS) form), which has the capacity to track cases from report to conclusion, allowing for intervention where necessary
- NHS health bodies to nominate a Security Management Director (SMD), a member of the executive board, to bear overall responsibility for

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1 Published on Department of Health website 10 June 2006.
2 Reference to Zero Tolerance and the Healthcare Commission Standards for Better Health C20a which states that health bodies must provide ‘a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation’.
security management work with particular responsibility for tackling violence.

2.4 The first framework also saw the creation of the NHS SMS Legal Protection Unit to provide NHS health bodies with cost-effective and consistent advice on a wide range of sanctions and to work with the police and the CPS to increase the rate of prosecutions. Where appropriate, the Legal Protection Unit can also conduct private criminal prosecutions or civil litigation to deal with individuals who threaten the safety of staff.

2.5 The second framework introduced the requirement for each NHS health body to nominate an LSMS to undergo professional accredited training to ensure that the highest standards can be applied to security management work locally in the NHS.

2.6 As well as the introduction of these two frameworks, explanatory notes on tackling physical assaults against NHS staff were issued to NHS health bodies in November 2003 (updated in 2007). Guidance on reporting and dealing with non-physical assaults against NHS staff and professionals was issued to NHS health bodies in November 2004.

2.7 The NHS SMS has a number of national initiatives and programmes of work to tackle the issue of violence and aggression in our healthcare system. However, work is in its early stages and it is recognised that a great deal of further work is required to address specific areas of concern.

The problem

2.8 In the financial year 2005–06, there were 58,695 physical assaults on NHS staff. There is no clear explanation of why this violence occurs, and research into this area identifies that it is a complex issue involving a number of risk factors. One framework for understanding violence in the workplace includes a range of factors seen to contribute to violence against and abuse of staff by members of the public. These concern aspects of the perpetrator (e.g. personality, substance abuse, unfounded expectations), the employee (e.g. sex, age, social status, experience), the type of interaction (e.g. caring, money/valuables issues, controlling), the situation (e.g. working alone, job location, waiting times) and the outcome. Researchers from the Tavistock Institute of Human Resources, conducting a review of the research into violence in the workplace for the Health and Safety Executive\(^5\), identified a number of risk factors from the various theories:

2.8.1 General risk factors
- mobile jobs, travelling frequently to and from the worksite
- working in an unsafe environment
- frequent involvement in transporting goods and passengers

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\(^3\) These documents are available from the security management section of www.cfsms.nhs.uk.


\(^5\) Review of Workplace Related Violence prepared by the Tavistock Institute for the Health and Safety Executive, 143/1997
2.8.2 **Context-related risk factors**
- remote workplace
- wide client base

2.8.3 **Organisation-related risk factors**
- operating after normal hours
- working away from base and alone
- low staffing levels

2.8.4 **Risk factors related to the characteristics of assailants**
- mental health history associated with violent behaviour
- higher promises of service bringing higher expectations
- drink and drugs
- having a physical advantage

2.8.5 **Employee-related risk factors**
- uniforms
- employee ill health and stress, which can affect patience and cause misunderstanding
- inexperience
- unrealistic expectations of the job.

2.9 Many of the above risk factors are present within the NHS, and violence in the workplace has a negative effect on efficiency and destroys staff morale, motivation and performance. This can have a negative effect on the working environment and staff/patient interaction, ultimately affecting the recruitment and retention of staff. A number of measures as outlined previously are now in place to tackle violence against staff generally. However, more is required in terms of targeting violence that occurs in specific areas of the NHS. Violence against staff where long-term care is provided is a particular problem, as it is more likely that violence will recur where patients have to re-attend for long-term treatment.

2.10 In areas such as Accident and Emergency (A&E) departments and ambulance services, patients are discharged or transferred to another unit or receiving hospital once they have been treated. In these areas, assaults on staff are usually carried out by patients or their accompanying friends or relatives.

2.11 In both situations, the effect of a violent attack is the same in terms of distress and trauma to the victim. In the long-term care environment, it is far more likely that staff will have to face the violent individual repeatedly and the attacker is more likely to be the patient than their friend or relative. In some areas, such as renal dialysis units, patients have to return regularly to the same unit or ward for treatment. This may be several times a week for an extended period – usually a number of years.
Case study

Patient A regularly attended a renal dialysis unit for haemodialysis treatment.

Over a 13-month period, 23 incidents of verbal abuse, threatening behaviour and physical assault committed by Patient A against 10 members of staff were recorded. These involved verbal abuse and remarks of a sexual nature, criminally offensive language, threats to harm and kill, stalking and one incident of physical assault.

All but one (a hospital manager) of the members of staff involved were nursing staff who regularly cared for Patient A. All of the 10 staff were abused by Patient A on at least one occasion – three of them more than once – with one member of staff receiving threats (involving both verbal abuse and threatening behaviour) on eight occasions.

2.12 The Nursing and Midwifery Council (NMC) also recognises this issue as one of great concern for the nursing community and believes that health bodies need to address the issue of staff who do not wish to treat an individual because of violence. In a letter to one NHS trust concerning violence in its renal unit, the NMC states that:

> it is very important for trust boards to take consideration locally of the support they need to give to the human rights of their staff as well as the human rights of their patients.

This issue needs to be balanced with the duty of care towards patients, as demonstrated by the Healthcare Commission’s inquiry\(^6\) into the care and treatment of Christopher Alder which stated that:

> all NHS organisations need to ensure that their policy for zero tolerance of violence and aggression towards staff is balanced between protecting the healthcare staff and protecting patients’ rights.

2.13 The NMC and Healthcare Commission views highlight the fact that measures taken to tackle violence and aggression in long-term treatment environments require recognition of the fact that staff-patient interaction in these settings is distinctly different from that in other healthcare environments, and of the burden patient expectation places on this relationship. In these particular environments, NHS staff will provide longer-term continuous care and assessment, due to the clinical severity of the medical conditions involved. Therefore, if a member of staff is subject to violence or aggression from a patient, there is a much higher probability of further recurrent interaction with the patient than there would be in other healthcare settings.

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\(^6\) Investigation into the care and treatment given to Christopher Alder by Hull Royal Infirmary and Humberside Ambulance Service NHS Trust prior to his death, Healthcare Commission: 2005.
Initiatives for tackling violence and aggression, such as withdrawing or withholding treatment, which may be applicable in other settings are often unsuitable for this type of environment. There are serious implications for healthcare staff and managers in considering taking action which would deny patients life-sustaining treatment. It is important that the possibility of violent and aggressive behaviour being in any way linked to the patient’s clinical condition, medication or treatment is fully explored. For example, lack of oxygen to the brain causes neurological problems which can result in erratic behaviour.

Deterrents, warnings, contracts and Anti-Social Behaviour Orders (Asbos) will be neither appropriate nor effective for patients whose violence and aggression arises from their clinical condition and who lack the capacity to control their behaviour. It is understandable for patients to be angry, upset or otherwise emotional when faced with a particular diagnosis or medical intervention/decision. Equally, relatives and friends may also become emotional; if not dealt with appropriately, this can exacerbate a situation. Sanctions that can be used to manage the behaviour of a violent or aggressive patient and provide a safe and secure environment for staff and patients are outlined in this guidance. However, sanctions will only work for patients with capacity to understand and take responsibility for their actions.

Further, access to appropriate education and training in dealing with this issue is variable or non-existent in some areas. This is also the case for post-incident care and review. Therefore, this issue requires that specific guidance be developed outlining the range of appropriate policies, procedures, systems and good practice that can be adopted in these environments.

This guidance is designed to reflect good practice throughout the NHS and other organisations to help protect NHS staff in the environments described. It provides information, primarily for LSMSs, risk managers, human resource departments and, even more importantly, the managers of the staff working in these areas and the staff themselves, about the policies and procedures which should be in place to provide the best protection for staff and patients.

The guidance is designed to be as comprehensive as possible but, inevitably, cannot cater for every situation that may occur within a working environment. With this in mind, it should be used as a template from which local procedures and systems to protect those NHS staff working in the long-term healthcare environment should be developed, revised or enhanced. These local arrangements should reflect the local needs of staff and the environments in which they work. Overall, this guidance aims to improve policy, practice and education in this important area.

To date, very little research has been carried out on the levels of violence within long-term healthcare environments. During an annual nephrology conference for the nursing profession held in March 2004, an anonymised survey of delegates was conducted to establish the extent and nature of the violence and aggression that delegates were experiencing in clinical practices. The response rate was 66% and 79% of respondents reported violence and aggression in the workplace, with the majority (64%) having had an experience during the previous year. The severity of attacks ranged from low-level assaults to a reported stabbing and reports of serious injuries such as a fractured sternum. The impact

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8 Eighty-six delegates attended the annual conference, representing all regions within the United Kingdom.
of such experiences resulted in increased levels of stress (65%), reduced levels of confidence (23%), and nearly all respondents reported verbal abuse.

2.20 Consequently, to support the development of this guidance, an expert group was established. Members contributed their experiences of what worked and what did not work in the course of tackling this problem locally. This guidance pulls together practical solutions identified by the expert group (see appendix 7 for the list of group members) and aims to make them widely available to all those who work in similar environments. The NHS SMS and key stakeholders including NHS professionals will support those working in the affected areas to implement the guidance locally.

Definition and background

2.21 Everyone has a duty to behave in an acceptable and appropriate manner. All NHS staff have a right to work, as patients have a right to be treated, free from fear of assault and abuse in an environment that is properly safe and secure.

2.22 To ensure that appropriate action is taken to tackle violence and aggression against staff and professionals working in the NHS, concise, consistent, legally-based definitions were introduced so that staff knew when to report non-physical and physical assaults (see paragraphs 2.23.1 and 2.24.1 below).

2.23 The NHS definition of non-physical assault:

2.23.1 ‘The use of inappropriate words or behaviour causing distress and/or constituting harassment.’

2.23.2 This definition ensures that NHS health bodies and staff are clear about what to report and can overcome local interpretations of what constitutes non-physical assault. The definition clearly identifies the impact on the individual.

2.23.3 It is difficult to provide a comprehensive list of types of incident that are covered under this definition; however, some examples are provided below:

- offensive language, verbal abuse and swearing
- racist comments
- loud and intrusive conversation
- unwanted or abusive remarks
- negative, malicious or stereotypical comments
- invasion of personal space
- brandishing of objects or weapons
- near misses i.e. unsuccessful physical assaults
- offensive gestures
- threats or risk of serious injury to NHS staff
- intimidation
- stalking
- alcohol or drug fuelled abuse

8 The expert group was made up of a number of NHS nursing and medical professionals, NHS managers, patient representative groups and academics working in various healthcare environments, such as nephrology and elderly care.
• incitement of others and/or disruptive behaviour
• unreasonable behaviour and non-cooperation such as repeated disregard of hospital visiting hours
• any of the above linked to destruction of or damage to property.

2.23.4 This list is not exhaustive but outlines the range of behaviour that falls within the NHS definition of non-physical assault. Such behaviour can be carried out in person or by telephone, letter, email or other forms of communication.

2.24 The NHS definition of physical assault:

2.24.1 ‘The intentional application of force to the person of another without lawful justification resulting in physical injury or discomfort.’

2.24.2 This definition ensures that NHS health bodies and staff are clear about what to report and can overcome local interpretations of what constitutes physical assault.

2.24.3 It is difficult to provide a comprehensive list of types of incident that are covered under this definition; however, some examples are provided below:

• spitting on/at staff
• pushing
• shoving
• poking or jabbing
• scratching and pinching
• throwing objects, substances or liquids onto a person
• punching and kicking
• hitting and slapping
• sexual assault
• incidents where reckless behaviour results in physical harm to others
• incidents where attempts are made to cause physical harm to others and fail.

2.24.4 This list is not exhaustive but outlines the range of behaviour that falls within the NHS definition of physical assault.

2.25 The reference to violent incidents within this guidance encompasses all types and levels of violence, ranging from non-physical assault\(^9\) such as swearing and verbal and racial abuse through to physical assault.

2.26 The effects of non-physical and physical assault are wide-ranging and it should be acknowledged that as well as the more evident impacts of a physical assault, such as a visible bruise or injury, there may often be non-evident, longer-lasting impacts such as emotional and psychological trauma. It is not necessary for there to be any physical injury as a result of the assault in order for further action to be taken.

\(^9\) See NHS SMS non-physical assault guidance for a description of types of incident that are covered under non-physical assault.
2.27 Indeed, the potentially serious degree of harm that can be inflicted without physical contact has led to successful prosecutions for actual bodily harm brought against stalkers as, in some cases, the offence was caused by telephone calls.

Action

2.28 Health bodies should have in place local policies and procedures that comply with all Directions issued by the Secretary of State on the management of violence and any guidance issued by the NHS SMS. This is supported by health and safety legislation, which also requires NHS bodies to have policies, procedures and communication strategies for tackling violence and aggression against staff.

2.29 Depending on the severity of the incident, a range of measures can be taken by NHS health bodies which may assist in the management of unacceptable behaviour by seeking to reduce the risks and demonstrate acceptable standards of behaviour. These may include:

- making staff aware of the process and the support available to them when a violent incident takes place
- educating staff about the importance of reporting procedures in ensuring that all violent incidents are recorded and appropriate measures taken
- post-incident support and counselling for staff to assist their return to work and encourage staff to remain working within long-term healthcare environments after such an event
- undertaking risk assessments in high-risk areas, to include the health body’s LSMS, health and safety officer and front-line staff
- the creation or development of a pro-security culture
- training and supervision
- verbal warnings
- behaviour agreements (see appendix 2)
- written warnings
- Acknowledgement of Responsibility Agreements (ARAs)
- acceptable behaviour contracts
- civil injunctions and Asbos
- criminal prosecution.

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The NHS SMS has identified seven generic areas of action for both proactive and reactive initiatives in relation to security management in the NHS. These include:

- engendering a pro-security culture
- deterring security incidents and breaches
- preventing security incidents and breaches
- detecting security incidents and breaches where they have not been prevented
- investigating security incidents and breaches in a professional, objective and fair manner where detected, and ensuring that lessons are learned and system weaknesses are fed into risk assessments and policy development and revision to prevent further breaches from occurring
- applying a wide range of sanctions where necessary
- seeking redress to ensure that funds are put back into the NHS for improved clinical care.
3 PRO-SECURITY CULTURE

3.1 The development of a pro-security culture is integral to all strands of security management work in the NHS. Building a pro-security culture is about taking an inclusive approach with all those involved – staff, managers, patients/service users and the public.

3.2 LSMSs should lead on work to develop a pro-security culture. Collective responsibility, partnership working and local ownership are essential to implementing robust procedures and systems.

3.3 Managers should communicate to staff what they can expect in terms of support and what is expected from them. Local procedures should include:

- the reporting process for violent incidents, including abuse
- the views of staff and their union, health and safety representatives or professional representatives
- the views of patients, service users and their representatives
- clear links to other relevant procedures and existing health body policies
- a clear outline of responsibilities and lines of accountability in respect of any action to tackle non-physical assaults
- legal advice from the NHS health body’s own legal team (or the NHS SMS Legal Protection Unit in specific cases) on the precise terms and application of procedures in appropriate cases
- guidelines for staff who feel that they cannot continue to deliver treatment in the event of any occurrence of violence, which must also include the organisation’s responsibility to provide care.

3.4 It is essential that NHS staff, at all levels, are made aware of their responsibility to be familiar and compliant with procedures that are in place for their protection. This may be facilitated using media such as:

- job descriptions
- staff handbooks
- clearly written procedures
- induction programmes
- knowledge and skills framework/personal development reviews
- presentations by LSMSs
- awareness-raising sessions by risk managers
- training (e.g. conflict resolution)
- team briefings
- health body intranet.

3.5 The above list is not exhaustive and LSMSs and NHS managers should consider using a combination of these options to achieve the desired outcome. In larger organisations, LSMSs may not be able to communicate directly with every staff member and should consider conveying information via managers.

3.6 Security systems and procedures should be reviewed on a regular basis, and at least annually.
3.7 NHS health bodies should endeavour to extend the pro-security culture to patients so that they are aware of their responsibility for their own actions and behaviour while on NHS premises. This can be facilitated by engaging with the health body’s Patient Advice and Liaison Services\(^{11}\) (PALS) and Race and Equality departments. NHS health bodies should also have a policy to tackle violence and abuse against their staff and make this policy widely known to both patients and staff. Such policies should be discussed and approved at board level. The LSMS can assist health bodies in the development of such policies and in creating a pro-security culture amongst NHS staff and service users.

3.8 Other measures include behaviour agreements and pledge/mission statements. As best practice, patients with capacity to do so should be asked to sign a behaviour agreement as part of the health body’s consent procedure when patients are consenting to treatment. A behaviour agreement is an intervention designed to engage an individual in acknowledging their antisocial/violent behaviour and its effect on others, with the aim of stopping that behaviour. It is a written agreement made between a person who has been involved in antisocial behaviour and the health body. This agreement should be an integral part of any violence prevention strategy as it can achieve long-term change and prevent more serious levels of violence.

3.9 Although referred to in this document as a behaviour agreement, this document is also known as an acceptable behaviour agreement or pre-treatment agreement and is not necessarily entered into after an incident; depending on the circumstances, it can also be entered into before an incident has occurred.

3.10 Care should be taken to explain the content of the agreement to ensure that patients fully understand the purpose of the document. Special consideration should be given to those for whom English is not a first language, those who are hearing or visually impaired, those with mental health/learning disabilities and those who may require further assistance in making sense of the document. The agreement should be signed by the patient and the member of staff who has explained the agreement and witnessed the patient signing the document. A copy of the signed agreement should be kept with the patient’s records. If an individual refuses to sign the agreement, this should be noted within the patient documentation, such as the nursing/medical notes. The agreement should also outline what sanctions will be taken if the individual fails to comply with the terms outlined. A range of sanctions that the health body may employ against an individual is further discussed in paragraph 8.3 of this document.

3.11 A generic behaviour agreement at appendix 2 can be adapted to local requirements. Any pledge/mission statements developed for ward/unit level should reflect the health body’s values and its tackling violence policy.

\(^{11}\) PALS are a central part of the new system of patient and public involvement (PPI) in England. They are available in all trusts. PALS provide information, confidential advice, support and assistance to service users. They also act on their behalf and liaise with NHS staff and managers where appropriate.
4 DETERRENCE

4.1 Using publicity and the media, both nationally and locally, is a highly effective method of promoting what the NHS is doing to better protect those who work in long-term healthcare environments.

4.2 Locally, LSMSs should establish good relationships with their health bodies’ press or media departments to ensure the appropriate level of publicity is in place for measures introduced by the health body to better protect staff. The media team at the NHS Counter Fraud and Security Management Service will provide support and guidance to NHS health bodies that wish to promote such measures with their local press and other media, to ensure that the required deterrent effect is achieved and staff are not put at further risk.

4.3 A true deterrent effect can only be achieved when:

4.3.1 there is some certainty that offenders will be apprehended
4.3.2 offenders understand that they will be punished for their actions. and
4.3.3 the sanctions that may be applied against them outweigh any perceived benefit they may derive from their actions.

4.4 NHS health bodies must encourage the reporting of all incidents, including those committed deliberately and those resulting from a medical condition. Only if all incidents are reported will the NHS SMS be able to gain a clear picture of the extent of the problem.

4.5 In addition, appropriate publicity of cases involving sanctions applied to those who have physically assaulted and/or verbally abused staff may deter others who may be minded to commit such acts. In this way, it can play a key role in helping to protect staff from physical and non-physical assaults.

4.6 It is also important that any measures that are implemented do not stigmatise the patient or give the impression of their being treated differently.

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12 The NHS CFSMS media team can be contacted by emailing CAD@cfsms.nhs.uk.
5 PREVENTION

5.1 Prevention is concerned with stopping incidents of violence from occurring in the first instance by using interventions to either eliminate or reduce the underlying risk factors or to reduce the recurrence of further incidents of violence and its ill effects. Prevention should be based on effective use of available information to ensure that the risk of future incidents can be minimised – this includes learning from operational experience and adopting an inclusive approach that involves staff.

5.2 The public health model best describes the steps that can be taken to reduce violence in long-term healthcare environments across the NHS. Using this perspective, the prevention of violence within NHS health bodies can be described as having three main dimensions – primary, secondary and tertiary (see appendix 1, which demonstrates the model in action). However, it is important that the possibility of violent and aggressive behaviour being in any way linked to the patient’s clinical condition is fully explored and treated appropriately. There may be other causes, such as a neurological condition, sudden onset of an infection or side effects of medication.

Case study

A patient terminally ill with a brain tumour became verbally aggressive. The aggression was thought to be related to the tumour, intra-cranial pressure, and the side effects of steroids being used to treat his condition. Adjustments to the patient’s medication produced an improvement in his mental state, and his normal personality returned.

5.3 Primary prevention is action taken to prevent violence before it occurs, such as the training of health professionals in conflict resolution skills, which enables staff to recognise the warning signs of a potentially violent situation and take steps to prevent it from escalating.

5.4 Secondary prevention is action taken to prevent violence when it is perceived to be imminent and/or to minimise the harm caused by a violent event and the immediate post-violence intervention aimed at preventing re-victimisation – for example, interventions to reduce the duration of violent events or damage inflicted. Secondary prevention activities occur in the short-term after the event.

5.5 Tertiary prevention occurs in the long-term after an event and is action taken to prevent or reduce the potential for physical and psychological harm to the parties involved and to inform primary and secondary prevention strategies. Tertiary prevention activities are aimed at treating and rehabilitating victims and perpetrators.
Primary prevention

5.6 Primary prevention aims to keep violence from occurring in the first instance and focuses on the wider issues, such as the socio-economic, environmental or cultural factors that contribute to the act of violence. This may also include clinical prevention and treatment. Moreover, there are some simple measures an organisation or individual can take to prevent violence; these include informing patients if there is a delay as they arrive for a clinic appointment and providing further updates while they wait, which may prevent potential incidents of violence resulting from frustration at lack of information.

5.7 Primary prevention seeks to change the knowledge, attitude and behaviour of the targeted audience. Therefore, primary prevention requires action at multiple levels:

- organisation/NHS health body
- management team
- individual worker
- service user/patient.

Organisation/NHS health body

5.7.1 Actions at the organisational level include:

- clear leadership in the form of a strong management structure
- compliance with secondary legislation by implementing a reporting system for incidents of violence
- developing a health body code of practice for the management of violence locally which ensures that all incidents are properly recorded and investigated
- reviewing existing policies – violence, complaints, post-incident review and behaviour agreements – to ensure they are comprehensive in meeting the health body’s needs
- reviewing the existing organisational culture (staff attitudes), including the health body’s pro-security culture
- ensuring a balanced skills mix of experienced and new staff
- maintaining staffing levels through recruitment and retention
- providing and maintaining a safe physical environment, such as by prioritising security during the design and planning of any refurbishment or new build and installing alarms and access controls.

5.7.2 Compliance with secondary legislation also means that NHS health bodies have a responsibility to adopt the national syllabus for conflict resolution training issued on 1 April 2004. Health bodies with existing training programmes should ensure that these fully meet the requirements of the national syllabus. Further, health bodies have a responsibility to ensure delivery of this training to all staff by 31 March 2008, with capacity to deal with new staff joining thereafter.

5.7.3 To help monitor the implementation of this syllabus and its effectiveness, health bodies must submit outline plans to the NHS SMS stating the numbers and categories of staff they intend to train each year, along with the chosen or intended methods of delivery. There are three means of
delivery (and combinations of these) for health bodies to choose from: in-
house trainers employed directly by the health body, the NHS Counter
Fraud and Security Management Service’s training service and private
training providers.

5.7.4 Prevention is about using information about an incident to minimise the
risk of similar incidents occurring in the future. NHS health bodies should
ensure that they have adequate arrangements in place to assess risk to
their staff. This information is needed to decide how to manage those
risks in an informed, rational and structured manner and to ensure that
the action taken is proportionate. Arrangements should also be put in
place to monitor and review the findings. Robust risk assessments
carried out locally, assessment of contributing factors, post-incident
reviews and analysis of reports and operational information may highlight
the need to introduce technology to minimise the risk of violence and
aggression. However, it is essential that appropriate back-up procedures
are in place to ensure safety if technology fails.

5.7.5 Various physical security measures add value alongside consistent and
thorough polices and procedures; these include:

- CCTV
- alarms
- panic buttons/alarms
- lone worker devices
- access control systems
- building design features that adhere to Secured by Design13.

5.7.6 Information on the implementation and use of these measures is
There is strong evidence that design changes which make the
environment more comfortable, aesthetically pleasing and informative
relieve stress amongst patients and increase satisfaction with the quality
of care provided. They can also reduce the levels of violence and
aggression. Design characteristics such as distance between
beds/treatment areas, reduced noise, improved lighting, better ventilation,
and more ergonomic designs are some of the features which help reduce
violence. These factors should be taken into account when planning any
new builds or refurbishment of existing healthcare premises. The LSMS
and health and safety manager/representative are an excellent resource
in terms of the security and safety risks within the health body and should
be consulted when any new builds or refurbishments are planned.

5.7.7 It is important to review how the existing environment is used to provide
care to patients. Factors to consider include the ward/unit layout, single
room facilities and where the nurses’ station is situated. Specific
consideration should be given to the placement of patients with a history
of violence or aggressive tendencies – should they be placed on a
ward/unit or in a single room? A thorough safety risk assessment should
be undertaken to weigh up, for example, the risk of staff being isolated
and perhaps not able to call for help when required if the patient is given

13 The Association of Chief Police Officers’ Secured by Design is a police initiative to encourage the adoption of crime
prevention measures at the building design stage. It aims to assist in reducing the opportunity for crime and the fear of
crime and creating a secure environment.
a single room with the calming effect this may have on the patient. Health bodies should consult the Health Building Notes (HBN) produced by Department of Health Estates and Facilities\textsuperscript{14} when planning a new build or refurbishment.

**Management Team**

5.7.8 Actions at the management team level include:

- the development of the **pro-security culture**
- ensuring that each worker is aware of their role and responsibility as regards the **prevention** and **deterrence** of violence
- assessing training needs and providing relevant and regular training
- ensuring that staff training skills are current and maintaining records of those staff who have attended training courses
- reviewing incidents as they occur to learn from them
- ensuring that staff report incidents.

5.7.9 The training needs of clinical staff may differ from those of non-clinical staff. The need to monitor and care for the patient's physical well-being during and after a violent episode as a specific duty of care should be included in training courses for clinical staff. Consideration should also be given to incorporating risk assessment and risk management strategies into all training courses.

5.7.10 There should also be agreement of an information sharing protocol with local police, social services and primary care providers such as GP surgeries, as they will have information on violent patients or other individuals who may pose a risk to NHS staff. If NHS health bodies have any concerns about confidentiality issues and disclosure of information, they should contact the NHS SMS Legal Protection Unit for advice.

5.7.11 All front-line staff (both full- and part-time) should be trained in conflict resolution techniques in line with the national NHS SMS strategy (see 5.7.2). ‘Front-line staff’ refers to every member of staff who has contact with patients and the public. Training should initially be focused on those who are most at risk, such as those who work in areas with a high incidence of physical or non-physical assault, those who have more frequent than average contact with patients and the public or those selected according to the health body’s risk assessment process. This training must include the 10 objectives from the national guidance, which are for delegates to be able to:

1. describe common causes of conflict
2. describe two forms of communication – verbal and non-verbal
3. give examples of how communication can break down
4. explain three examples of communication models that can assist in conflict resolution

\textsuperscript{14} DH Estates and Facilities produces guidance for NHS organisations and individuals with an interest in land, property, equipment and facilities. The majority of DH Estates and Facilities guidance documents are published as part of the following series: Health Building Notes (HBN), Health Technical Memoranda (HTM) and Model Engineering Specifications (MES).
5. describe patterns of behaviour they may encounter during different interactions
6. explain the different warning and danger signs
7. give examples of impact factors
8. describe the use of distance when dealing with conflict
9. explain the use of ‘reasonable force’ as it applies to conflict resolution
10. describe different methods for dealing with possible conflict situations.

5.7.12 All undergraduate front-line staff (including allied health professionals) should also receive conflict resolution training at pre-registration stage. This should cover the effects of alcohol and illicit drug use as causal factors in violence and their possible interactions with prescribed medication and treatments.

5.7.13 Training needs analysis should dictate what other training might be required in the different healthcare environments. It may be necessary to train staff on safe and ethical disengagement techniques; risk assessment would indicate need. Detailed guidance based on best practice covering physical interventions within healthcare settings is currently being developed by the National Patient Safety Agency and National Institute of Mental Health in England. Managers must also ensure that staff who have not received the appropriate training do not take part in planned physical intervention, other than in exceptional circumstances.

5.7.14 A key part of the delivery of healthcare to people with long-term conditions is the ability to communicate effectively and provide good customer service. Training in this area should be provided as part of the induction process for new staff as well as on an ongoing basis for existing staff.

5.7.15 It is essential that staff are encouraged to report identified risks, as well as incidents that have or may have occurred, to managers, so that the appropriate action can be taken and the LSMS informed about any incident of violence, so it can be properly investigated. Appropriate action also refers to alerting all staff who will come into contact with the individual who has been identified as a risk. Although such episodes should be well documented, not all staff who work in the NHS will have access to this information. Some may simply not access it before dealing with the individual in question. Management must explore fully the risks to all staff and communicate with all staff who may potentially be at risk of violence – for example, staff coming on duty who may not have been on the ward for a few days, cleaning and catering staff and those staff not based on the ward, such as those taking blood samples for investigation.

Individual worker

5.7.16 Actions at the level of the individual worker include adhering to the health body’s policy on the management of violence, reporting incidents as they occur and taking ownership to ensure that their training skills are up to date and current. Individual staff have a responsibility to undertake conflict resolution training provided by their health body and keep a
record of their own training certificates. As highlighted in 5.7.2 and 5.7.3, health bodies are required to ensure their staff are trained to the standard of the national syllabus in conflict resolution. This training will educate staff on non-verbal and verbal communication skills, models of communication, patterns of behaviour, warning signs and trigger points, impact factors, such as alcohol or drugs, and the safe distance staff should keep when dealing with conflict.

5.7.17 However, conflict resolution training does not fully examine the reasons why individuals are violent. It is anticipated that patients may be angry and/or upset when faced with a poor prognosis and the probability of death as a result. Equally, relatives, friends and families may also become emotional – which, if staff feel unprepared or unable to deal with difficult questions about death, can exacerbate rather than defuse the situation. There will be other influences on the behaviour of the individual, such as a history of violence within a family or social group, alcohol or substance misuse and socio-economic factors such as financial hardship. This type of information will be gathered during patient assessments (see appendix 5 for an assessment tool template to assist in this process). Aggressive or abusive behaviour may also be the result of poor communication with staff, the reaction to what the individual may perceive as unfair or poor service, or a complete breakdown in communication between the two parties.

5.7.18 Therefore, healthcare staff should keep in mind and be aware of the possible reasons why an individual is displaying aggressive or abusive behaviour, because the patient’s clinical condition may contribute to their behaviour. However, a physical assault which occurs due to a patient’s clinical condition must still be reported to the NHS SMS.

5.7.19 It is important that healthcare professionals are equipped with the skills to communicate effectively with patients and their carers. This is particularly important for those who have to communicate particularly complex or distressing information. Staff in this group should be provided with training to enhance their communication skills or have access to those who have these skills. It is important that healthcare staff do not make assumptions about the level of information required by their patients; rather, they should engage with them and ask them what they want to know.

5.7.20 As well as enhancing overall communication skills, staff should be trained in sensitive listening, communicating significant news, explaining complex treatment options, exploring uncertainty (such as in poor prognosis) and discussing end-of-life issues. Training staff how to communicate significant/bad news in a sensitive and appropriate manner can prevent the escalation of a situation into a violent incident. It is also critical that staff are trained to communicate effectively with people with hearing, sight, speech or combined sensory disabilities, those with learning disabilities, people whose preferred language is not English and those from different cultural groups.

5.7.21 Most healthcare staff would have access to specialist palliative care teams who are expert in the support and care of patients with complex palliative care needs, which include psychological needs relating to death and dying. There is guidance on the delivery of difficult information to
patients issued by the National Institute of Clinical Excellence. Although this guidance has been issued for cancer services, the principles are applicable to any clinical group.

Service user/patient

5.7.22 Action at the level of the service user/patient relates to individual care planning and patient expectation. Each service user having treatment within the NHS must have a care plan. Where violence is an issue, this plan must identify underlying problems which will be picked up on as part of the patient assessment. Appendix 5 provides an assessment tool template to assist nursing staff when carrying out an assessment for care-planning. Action in this area also includes participation in and adherence to any behaviour agreement on the part of the service user.

5.7.23 As best practice, NHS health bodies should have a behaviour agreement in place. This is a written agreement between staff and patients set by the NHS health body. It gives an opportunity for local issues and concerns to be addressed and allows the patient’s expectations to be managed by staff. An example of such an agreement is given in appendix 2 of this document and lists the type of content needed. It should be noted that this list is not exhaustive. Engaging mental health professionals and psychologists to advise staff on units where there is a history of violence will also be beneficial to the individual care-planning.

Secondary prevention

5.8 Secondary prevention is focused on reducing the prevalence of the problem by minimising known or suspected risk factors and by early intervention i.e. when violence is perceived to be imminent or immediately post-incident. While it is not appropriate for the NHS SMS to give clinical staff specific advice on the prevention and treatment of violence and aggression arising from the patient’s clinical condition, it is suggested that within secondary prevention, action would include prompt medical review after a violent and/or aggressive incident. Action in this area can be planned or unplanned. In some areas of the NHS, the incidence of violence is highly predictable – therefore, this knowledge can be used proactively to plan positive interventions such as training staff to recognise warning signs and in de-escalation strategies so they can defuse a potentially violent incident.

5.9 This involves staff using a dynamic risk assessment immediately before an incident occurs or while it is occurring. A dynamic risk assessment can be defined as a continuous process of identifying hazards and risks and taking steps to eliminate or reduce them in the rapidly changing circumstances of an incident. The dynamic risk assessment involves staff:

5.9.1 being alert to warning signs as covered in conflict resolution training
5.9.2 carrying out a ‘10-second risk assessment’; if staff feel there is a risk of harm to themselves, they should leave immediately
5.9.3 placing themselves in a position to make a good escape
5.9.4 making a judgement as to the best possible course of action – for example, whether to continue working or withdraw. At no point should a staff member place themselves, their colleagues or their patients/service users at risk or in actual danger.

5.9.5 utilising appropriate physical security measures e.g. triggering panic buttons to call assistance from staff nearby/security/the LSMS/the police, or using a lone worker device such as Identicom.

5.9.6 ensuring that when they enter a confined area or room, they make sure they can operate the door lock in case they need to make an emergency exit.

5.9.7 avoiding walking in front of a patient/service user, and not positioning themselves in a corner or in a situation where it may be difficult to escape.

5.9.8 remaining calm and focused during an incident in order to make rational judgements.

5.10 Staff should be aware of their body language (as well as that of the patient/service user), as there is a risk of exacerbating the situation by sending out the wrong signals, particularly if there are cultural, gender or physical issues to consider. Body language and other forms of non-verbal communication and mannerisms play an important role in how people perceive and behave towards others. Specific training in non-physical intervention skills, customer service and de-escalation is essential and all front-line staff must be trained in the national syllabus for conflict resolution, with additional training provided over and above this, depending on the risks faced and individual needs.

5.11 Managers and staff should discuss what actions they should take in the event of an incident. Managers should check whether this is covered by local tackling violence policies and amend them as necessary. The flowchart at appendix 3 outlines suggested action for individuals when an incident of violence or abuse is occurring.

5.12 Initially, this involves notifying the police, LSMS or health body security staff. The senior nurse/bleep holder/ward manager responsible for the staff involved and the doctor on call/consultant in charge of the patient’s care should also be notified. These individuals all have their own responsibilities in the event of an incident:

5.12.1 The police – if appropriate, to make an arrest, take witness statements, gather evidence, conduct an investigation and secure the area if required.

5.12.2 The LSMS – to conduct an investigation, gather evidence and identify security breaches and any failures in systems and processes. The LSMS should complete an incident report and a physical assault reporting system (PARS) form if there is a physical assault.

5.12.3 Security staff (in some trusts, security staff may be the first point of contact) – to engage with the violent individual, ask them to leave the

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15 The NHS SMS has a memorandum of understanding (MoU) with the Association of Chief Police Officers that covers prevention, detection and investigation work and application of sanctions in respect of security matters within the NHS. The MoU requires LSMSs and local police to have a protocol in place to work together.
premises, escort them from the premises (see 5.12.5 for the Healthcare Commission’s national recommendation on this issue) and secure the area if required. If the violent individual is an inpatient, security staff will still need to engage with them to assist in resolving the incident. In conjunction with the senior nurse and consultant in charge of the individual’s care, security staff should be involved in a review of where the patient is being treated and consider whether they should be moved temporarily or transferred to another environment.

5.12.4 The senior nurse/general manager – to provide support to the staff involved in the incident, debrief them and, if they are injured, ensure they receive appropriate treatment and are referred to an occupational health practitioner and/or counsellor. The senior nurse/general manager will also need to document the incident and decide whether to continue operations or evacuate the area. This will involve making alternative staffing arrangements and ensuring that staff involved are able to continue with their duties.

5.12.5 The senior nurse/consultant also has a duty of care towards the patient. While it is not appropriate for the NHS SMS to give specific advice on clinical aspects of care, it is suggested that this duty of care may include beginning to assess whether the patient understands and can take responsibility for their own actions, and whether there is an underlying clinical cause of their behaviour, as well as assessing and treating any injuries. In line with the Healthcare Commission’s national recommendations following the Christopher Alder inquiry, staff must ensure that:

patients whom they consider to be aggressive or violent are assessed as to their fitness for discharge by a senior doctor prior to their leaving the department, particularly where there is a risk of a head injury. The assessment must be recorded in their notes.

5.13 In the short-term – ideally, after the incident has been resolved – there should be a post-incident review. This is an evaluation of the incident response, used to identify and correct weaknesses, as well as to determine strengths and publicise them. It is important for a review to take place as quickly as possible while the memories of those involved are still fresh. However, the trauma suffered by any individual(s) must be taken account of. The review is the time to learn from what happened and use these lessons to enhance the health body’s policies and systems. It is best to do this as a matter of urgency rather than lose the opportunity. There are several questions that should be asked during the review:

- What can be learned from what happened?
- How can we avoid repeating mistakes?
- How can we assess what is and is not working?
- What are the implications of what just happened, not only on the health body, but also on the whole local health community?
- Are policy and system revisions needed?

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16 Investigation into the care and treatment given to Christopher Alder by Hull Royal Infirmary and Humberside Ambulance Service NHS Trust prior to his death, Healthcare Commission: 2005.
Tertiary prevention

5.14 Action at this stage focuses on the long term; while secondary prevention is reactive, tertiary prevention deals with the aftermath. Tertiary prevention is about minimising the effects of violence as well as preventing its occurrence. The key to preventative action is an honest and objective appraisal of how and why incidents can occur in long-term healthcare environments and the ability to learn from this. To achieve this, a post-incident review should be carried out. This review differs from that discussed under secondary prevention as it deals with the long term and is more detailed. It requires an analysis of the incident and the following factors should be considered:

5.14.1 Type of incident, i.e. non-physical or physical assault. Weaknesses or failures that have allowed the incident to take place – for example, procedural, system or technological. Examine what lessons can be learned and actioned by the health body to avert or better manage similar situations.

5.14.2 Severity of incident in terms of extent of injuries (i.e. were there broken bones; do the injuries require hospitalisation of the affected staff member; is surgical intervention needed?) and the period of time taken off by staff to recover.

5.14.3 Cost to the health body in both human and financial terms. For example, if staff take long-term sick leave following an incident, the cost to replace them and, if staff leave because of the incident, the costs of recruitment.

5.14.4 The actions of individuals and staff groups involved. It is important to establish whether staff have been involved in an incident before, as this may suggest that the environment in which they work needs to be addressed. Assessment of the patient pathway and how people are managed through systems is also important. Where skill gaps are identified, further training should be provided.

5.14.5 The care of the individual concerned to avert future incidents and ensure that any history of violence is reflected in their care plan. While it is not appropriate for the NHS SMS to give specific advice on clinical aspects of care, it is suggested that action within tertiary prevention might include, for example, appropriate rehabilitation for brain-injured patients demonstrating repeated violence and aggression.

Case study

On a medical ward, a patient appeared disorientated and unexpectedly struck out at staff. When the immediate situation had been managed and the patient had calmed down, blood tests revealed he had low sodium levels. When this was resolved, he suffered no further episodes of confusion or aggression.
5.14.6 Measures in place to manage risk, and the appropriate use and operation of technology such as CCTV.

5.15 In the long term, analysis of security incidents can identify trends and patterns which can inform the revision of policies and procedures. Prevention is about using information to minimise the risk of similar future incidents. NHS health bodies should ensure they have adequate arrangements for assessing risk to staff and carry out robust risk assessments locally. This information is needed to make informed, rational and structured decisions about how to manage those risks so that the action taken is proportionate. Arrangements also need to be put in place to monitor and review the findings.

5.16 It is important that the health body provide its staff with a range of flexible support that they can access at their discretion. This might include an occupational health department, or telephone counselling/peer support briefings/provision for staff to work in other areas during the treatment of a known violent individual.

5.17 Tertiary prevention also concerns the sanctions and redress pursued by the health body against individuals who are violent towards their staff. These are discussed further in sections 8 and 9 of this document.
6 DETECTION

6.1 Detection and incident reporting are integral parts of the security management process. They allow the necessary information to be gathered to:

6.1.1 identify the problem

6.1.2 assess and manage the risk

6.1.3 develop solutions.

6.2 Incident reporting is key to the detection of assaults. Detection allows appropriate incidents of non-physical and physical assault to be investigated by professionally trained LSMSs to ensure that lessons learnt can be fed back into management procedures. It also facilitates the development or revision of policy, procedures and systems to ensure that the risk of similar incidents occurring again can be minimised.

Case study

A patient threatened staff and suggested that when he did attack someone he would hit a nurse rather than a doctor because he felt no action would be taken for hitting a nurse. Staff were encouraged to record such threats and these records were given to the police when the person did go on to assault a nurse. He was found guilty of common assault at a magistrates’ court. He received a £100 court fine and was ordered to pay £50 court costs and £100 compensation to the staff member.

6.3 This case study highlights two important points. First, the staff involved reported the threats made by the patient. Second, when an assault occurred, they brought the documented information to the attention of the investigating police officers, who in turn presented the information to the CPS, which was prosecuting the individual. The Code for Crown Prosecutors outlines that the more serious the offence, the more likely it is that a prosecution will be in the public interest. An offence committed against a person serving the public, such as a nurse, and evidence that the offence is likely to be continued or repeated, such as a history of recurring conduct, makes a prosecution more likely.

6.4 Moreover, the Sentencing Guidelines Council Guidance on determining seriousness when sentencing offenders takes the following factors into account: the failure on the part of the offender to respond to warnings or concerns expressed by others about their behaviour; sustained or repeated assaults on a particular victim; and whether the offence is committed against those working in the public sector or providing a service to the public.

6.5 This demonstrates that reporting incidents is important. It also highlights the need to bring the history of events that led to the assault to the attention of the police, CPS and NHS SMS. This should include any documented record of verbal threats prior to the incident and state whether it is a particular individual (e.g. female nurse) or group of individuals with a common identifiable feature (e.g. race, religion or gender) or a specific occupation (e.g. nurses or doctors) being targeted. This information and the fact that the assault is against a public sector worker makes it more likely for a case to be taken to prosecution. All staff should, therefore, be made aware of which, how, when and to whom incidents of non-physical and physical assault\(^\text{19}\) should be reported. All physical assaults should be reported to the LSMS, who should then submit a completed PARS form (see appendix 6) to the NHS SMS.

6.6 Following an alleged physical assault on a member of staff, the police should be contacted immediately by the person assaulted, their manager or relevant colleague. The exception is in those cases where the SMD in the health body, having consulted with relevant staff and obtained clinical advice, has reached the conclusion that the assault was not intentional and that the patient did not know what they were doing, or did not know that what they were doing was wrong, due to the nature of their medical illness, mental illness or severe learning disability or the medication administered to treat such a condition. The view of the person assaulted should also be sought in each incident.

6.7 Reporting incidents will ensure that any lessons learnt can be fed back into risk management processes, and that further preventative measures can be developed and sanctions applied where appropriate. In turn, these examples can be used to increase publicity to enhance the deterrent effect.

6.8 This will also assist in the review of procedures, ensuring that they are developed and revised to minimise the risk of similar incidents occurring in the future.

6.9 In short, this fosters a pro-security culture amongst NHS staff and professionals, raising their awareness of how and why incidents should be reported, how this facilitates the prevention process and helps to ensure their security and safety. Reporting physical assaults also allows the NHS SMS to link incidents and identify patterns of behaviour (e.g. individuals moving between health bodies) so that the appropriate action can be taken.

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\(^{19}\) See Secretary of State Directions, November 2003.
7 INCIDENT INVESTIGATION

7.1 Following an incident that has or might have occurred, the LSMS (or, where an LSMS has not yet been appointed, the SMD) must ensure that effective arrangements have been put in place to make certain that incidents, including potential risks, are reported and dealt with in accordance with the national legal frameworks for tackling violence and security management work.

7.2 If the incident involves a physical assault on an NHS staff member, it must be reported, a PARS form submitted to the NHS SMS (see appendix 6) through the LSMS and the incident investigated according to the national framework for tackling violence against NHS staff issued in November 2003 and the guidance to underpin this, published in May 2004.

7.3 If the incident involves a non-physical assault, such as verbal abuse, it must be reported, investigated and dealt with according to the national framework and the underpinning guidance issued in November 2004.

7.4 In all cases, irrespective of whether the health body or the police are pursuing sanctions against offenders, the LSMS should conduct an investigation to establish the causes of the incident and whether any further action needs to be taken in the areas of pro-security culture, deterrence, prevention or detection.

7.5 Written reports of violence must be submitted to the health body board with a view to facilitating informed, needs-led decision making regarding policy, training, practice and facilities in relation to the prevention and management of violence. It is essential that, where lessons can be learned, they are fed into revisions of procedures and systems locally, as well as guidance nationally, to ensure that staff are provided with the best possible protection and the risks they face minimised. The structure of LSMSs and SMDs locally across the NHS, with central support from the NHS SMS, will ensure that there is an effective mechanism in place to facilitate this process.
8 SANCTIONS

8.1 There is a range of sanctions which can be taken against those who abuse NHS staff and professionals or steal or damage NHS property. These include criminal prosecutions, Asbos and civil injunctions.

8.2 Advice, guidance and support on the range of sanctions that are available to deal with offenders can be obtained from the NHS SMS Legal Protection Unit, which can be contacted by emailing lpu@cfsms.nhs.uk.

8.3 When a physical or verbal assault takes place, there are various actions and sanctions which health bodies can pursue either directly or in cooperation with the criminal justice agencies. These include (in no particular order):

8.3.1 a verbal warning

8.3.2 an Acknowledgement of Responsibility Agreement or Behaviour Agreement (see appendix 2) – an intervention designed to engage an individual in acknowledging his or her antisocial behaviour and its effect on others, with the aim of stopping that behaviour

8.3.3 a written warning letter signed by a senior member of staff deemed by the health body to have the suitable level of authority, such as the Director of Nursing or the consultant in charge of the individual’s care. A warning letter may also be sent by the NHS SMS Legal Protection Unit if appropriate. A template of a warning letter which health bodies can amend accordingly can be found at appendix 4

8.3.4 local sanctions, such as managed visits whereby a known violent patient is escorted at all times by security staff when on health body premises, or police involvement

8.3.5 injunctions and civil sanctions

8.3.6 conditional cautions/Asbos

8.3.8 criminal sanctions

8.3.9 bail conditions.

8.4 All health bodies should have a policy in place for patients who are persistently violent (verbal and/or physical). NHS health bodies should also consider other options which can be used in isolation or in conjunction with the above range of sanctions. These can include the following:

8.4.1 Treatment at home

Because this option would place those staff going out to the patient’s home in a more vulnerable position, a risk assessment should be undertaken before they do so. The risk assessment should be conducted

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by suitably trained individuals and is likely to highlight the need for more than one staff member to attend – or, indeed, through local arrangement, a police or security presence. While it is not appropriate for the NHS SMS to give specific advice on clinical aspects of care, it is suggested that consideration is given to whether the patient can self-treat at home. Where appropriate, a patient may be provided with instruction, guidance and the relevant medication and equipment in order to self-treat.

8.4.2 Secure room

Health bodies may consider having a secure room on site that is equipped for those individuals who require treatment in a hospital environment. Depending on the location of the secure room, staff here could be put in a vulnerable position. This should be considered at the planning stage and a risk assessment undertaken to examine the need for additional security measures. These might include one-way mirrors to enable surveillance, and alarms and monitors that can be observed by other staff (security or nursing) at a workstation. Consideration should also be given to the escape route from these rooms. The health body should consult their LSMS when planning any new builds or refurbishments.

8.4.3 Using other facilities

Health bodies may wish to consider using other facilities, such as a local health centre or on-site mental health unit, which are already equipped with secure facilities.

8.4.4 Using the independent sector

The health body may consider using a private provider to deliver the care. Some providers in the independent sector may have the facilities to provide the care required in a secure area.

8.4.5 Referring individuals to primary care for treatment where appropriate

With the introduction of Local Improvement Finance Trust (LIFT) projects in primary care, PCTs are now able to provide a wider range of modern integrated health services in high-quality premises, fit for purpose for primary care.

8.4.6 Using a cooperative approach

Health bodies should also consider adopting a cooperative approach; this involves working with other health bodies and organisations to create a scheme specifically for patients who are persistently violent. For instance, local trusts can agree to treat such violent patients at a particular unit within a particular trust. The cost and human resources should be shared and regularly reviewed to ensure the arrangement is working effectively.

8.5 Sanctions are considered an effective way of deterring individuals from committing an offence. The type of sanctions applied should be proportionate to the nature and gravity of the incident(s). Therefore, the sanctions listed in 8.3 do not have to be considered in any set order. For example, if a patient has
physically assaulted a member of staff and caused injury, the health body can immediately consider criminal and/or civil sanctions if appropriate.
9 REDRESS

9.1 Whether they involve assaults on staff or theft of or damage to NHS property, the types of incident discussed above have a direct impact on both the human and financial resources which are allocated to the NHS and needed to deliver high-quality patient care. Through effective investigative work by the LSMS, the health body will be able to identify resources lost as a direct result of an incident, providing the necessary information and evidence to attempt to recover that loss, whether through the criminal courts, by way of compensation, or by seeking redress through the civil courts.

9.2 There are various routes by which effective redress can be sought. Monies lost through violent incidents against NHS staff or theft or damage to NHS property can be subject to an application to the courts for compensation and victims of physical assault may be able to apply to the Criminal Injuries Compensation Authority.

9.3 Recovery of losses delivers an important deterrent message to staff, patients/service users and the public: that the NHS will always pursue redress from those who abuse the service or its staff and deprive it of its valuable resources.
10 CONCLUSION

10.1 NHS health bodies have a duty to both their staff and patients. This includes their responsibility to embrace this guidance fully and adapt it for local use. Clinical relationships are reciprocal by nature; service users/patients must be provided with the best care, in circumstances which are therapeutic both physically and emotionally, and staff providing that care may expect reasonable behaviour from those receiving it.

10.2 The occurrence of violence against staff where long-term care is provided is a particular problem, as it is more likely that violence will recur where patients have to re-attend for long-term treatment. The measures outlined in this document can be implemented by NHS health bodies to alleviate and/or manage this problem.

10.3 Many NHS health bodies will already have procedures and systems in place to deal with this problem. However, with the introduction of this guidance, these should be reviewed and the content of this document taken into account and implemented locally.

10.4 In an organisation as large and diverse as the NHS, implementation of this guidance will require a joint and coordinated approach at strategic and local level. The NHS SMS is already committed to taking action against those who are verbally or physically abusive towards staff and will continue to seek measurable improvements in providing a safe environment for the NHS. However, each NHS health body should recognise the potential for violence within its environment and take the necessary steps to prevent and manage violent behaviour in patients and those attending NHS wards and hospitals.
11 APPENDICES

- Appendix 1 – Prevention of violence model
- Appendix 2 – Behaviour agreement
- Appendix 3 – Suggested management of violent/abuse incident flowchart
- Appendix 4 – Warning letter template
- Appendix 5 – Assessment tool template
- Appendix 6 – Physical assault reporting system form
- Appendix 7 – Working group members and consulted bodies
Prevention of violence model

The public health model best describes the steps that can be taken to reduce violence in long-term healthcare environments across the NHS. This model is used to provide a visual reference of how the guidance will work. The model is discussed in depth in Section 5 of this document.
Behaviour agreement

1. All individuals will be treated with consideration, respect, sensitivity and compassion, regardless of age, race, gender, religion, national origin, sexual orientation or any physical or mental disability.

2. All individuals’ right for privacy and dignity will be respected.

3. All individuals will agree to follow the treatment/care plans.

4. Treatment/appointment times will be recognised and adhered to as closely as possible and any delays in treatment will be explained.

5. All individuals entering National Health Service (NHS) health body premises are expected to take responsibility for their own property, leave valuables at home and only bring necessary items with them.

6. All those working in or receiving treatment from NHS health bodies need to understand that there are pressures and limitations on the resources of the NHS and those working within it.

7. All individuals on NHS premises have the right to work or receive treatment in a safe and secure environment without the fear of intimidation, assault or abuse.

8. NHS staff should involve patients, and carers and relatives as appropriate, in any decisions about the patient’s care and take into account their individuals needs.

9. Communication between staff and patients should be in clear, plain language without the use of medical jargon.

10. All those who use NHS environments should have access to information about NHS health bodies’ services, facilities and procedures.

11. All policies and procedures will be clearly explained and, if necessary, information made available to clarify any uncertainties – for example, the hospital’s discharge policy.

12. All policies and procedures must be followed. For example, the NHS policy of no smoking on NHS premises and the health body’s policies on visitors/noise/privacy/prohibition of illegal drugs and weapons, to ensure the safety and comfort of staff and patients.

13. Information needs to be shared in a timely manner so patients can make informed choices and staff can plan appropriate treatment. All requests and queries will be dealt with within a reasonable time.

14. All those who use the NHS must ensure they show respect for its property and equipment. Theft of or damage to NHS property and equipment will be reported to the police.

15. Violent and/or aggressive behaviour will not be tolerated. It is NHS policy to ensure appropriate sanctions are pursued and, where appropriate, incidents are reported to the police.
Suggested management of violent/abuse incident

**Incident occurs**

**Immediate/imminent danger?**

- Yes
  - **Primary tasks:**
    1. **Contact:**
       - (a) police
       - (b) trust security
       - (c) LSMS.
    2. **Decide whether to continue operations or evacuate.**

- No
  - **Secondary tasks:**
    - Notify nurse/general manager. Notify doctor/consultant on call.
    - Identify the lead person or team to coordinate incident.

**Initial incident dealt with?**

- Yes
  - 1. Notify bleep-holder/manager.
  - 2. Complete an incident report form or a serious untoward incident form.
  - 3. Complete PARS form if physical assault and inform LSMS.

- No
  - **Post-incident review process begins:**
    - medical review (consultant/doctor)
    - logistical review (bed manager)
    - security review (LSMS) including LSMS investigation as appropriate
    - quantify/regulate (risk management)
    - provide counselling/support as appropriate to employee or other individuals affected by incident
    - follow up on all witnesses to the incident
    - conduct risk assessment.

- **Provide feedback on processes/systems in place, identified weaknesses and lessons learned.**

**END**
Warning letter template

<Date>

Dear

Ref: Incident on <insert date and location>

As the Consultant in charge of your care, I am writing to you concerning an incident that occurred on <insert date> at <insert name of health body or location>.

It is alleged that you, <insert name>, used/threatened unlawful violence/acted in an antisocial manner towards a member of NHS staff/whilst on NHS premises (delete as applicable).

Behaviour such as this is unacceptable and will not be tolerated. This trust is firmly of the view that all those who work in or provide services to the NHS have the right to do so without fear of violence or abuse.

If you continue to act in an unacceptable or antisocial manner, consideration will be given to one or more of the following actions (to be adjusted as appropriate):

- The matter may be reported to the police with a view to this health body supporting a criminal prosecution by the Crown Prosecution Service.
- The matter may be reported to the NHS Security Management Service’s Legal Protection Unit with a view to this health body supporting criminal or civil proceedings or other sanctions. Any legal costs incurred will be sought from you.
- Consideration may be given to obtaining a civil injunction or an Anti-Social Behaviour Order. Any legal costs incurred will be sought from you.
- Alternative arrangements may be made for you to receive your treatment elsewhere and any hospital transport service currently provided to you may be withdrawn.

If you consider that your alleged behaviour has been misrepresented in any way or that this warning letter is unwarranted, please write to <insert details of person in charge of local complaints procedure>, who will review this decision in the light of your account of the incident(s).

A copy of this letter will be placed on your medical file and a copy has been sent to your General Practitioner.

Yours sincerely,

Consultant in charge of care
Prevention and management of violence and abuse
Assessment tool template

This assessment tool is designed to help nursing staff assess patients with a potential for violence or a history of violence and abuse against NHS staff, to achieve a consistent approach. It should be used in conjunction with the information and strategies outlined in this guidance. The tool may be used on its own or as part of an overall nursing assessment and the information gathered used to inform the patient's care plan.

<table>
<thead>
<tr>
<th>Problem: Violence and abusive behaviour relating to a history of harm to self or others, destruction of property, overtly aggressive acts and verbal threats of physical assault.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aim: To recognise, prevent and safely manage any act, or potential act, of violent or abusive behaviour without compromising the therapeutic needs of the patient.</td>
</tr>
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<table>
<thead>
<tr>
<th>Assessment</th>
<th>Nursing intervention</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Assess patient’s potential for violence and abusive behaviour through history, patient interview (or interview with family and friends if patient is unable to communicate), medical and nursing notes and information provided from other allied organisations/individuals, such as Social Services, patient’s GP etc.</td>
<td>• Before meeting with the patient, examine their medical and nursing notes to check for any incidents of violence and abusive behaviour that have been documented and how they were managed. • Introduce yourself and explain any procedure in plain and simple terms. Try to build a rapport with the patient to put them at ease during the assessment interview. • If appropriate and safe to do so, explore the patient’s history with them and explain the health body’s policy regarding violence and abuse against staff.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>2 Assess whether patient has any communication difficulties and explore possible reasons for this (e.g. sensory impairment, learning disability or English not being their first language).</td>
<td>• If there are communication difficulties, try to arrange for a family member or significant other to be present to assist during the assessment. You should always try to obtain the patient’s consent for this first. • If the patient is hearing impaired, ensure that hearing aid equipment is set and working properly or arrange for a BSL interpreter to be present for the assessment. • If the patient’s first language is not English, it may be appropriate to arrange for an interpreter to be present.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Step</td>
<td>Description</td>
<td>Notes</td>
</tr>
<tr>
<td>------</td>
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<tr>
<td>3</td>
<td>It may be useful to engage with family and/or friends to establish if there is any history of violence or abusive behaviour within the family. To maintain patient confidentiality, establish whether or not the patient has advised their significant others/family of their condition. However, be aware that family dynamics may be a cause of patients’ violence and judge whether or not to proceed with engaging with family. Establish level of support available to the patient from family or significant others.</td>
<td>Employ family members and significant others to enforce message that violence or abuse is not tolerated within the healthcare environment.</td>
</tr>
<tr>
<td>4</td>
<td>Assess patient’s attitude to admission/treatment and medical condition.</td>
<td>Answer any questions the patient may have concerning their admission, treatment or diagnosis and try to alleviate any anxiety. Arrange for the patient’s doctor, or other relevant members of the multi-disciplinary team (MDT), to discuss their condition with them if necessary.</td>
</tr>
<tr>
<td>5</td>
<td>Assess patient’s current physical and mental health, current medication and any substance use and misuse.</td>
<td>If there are any concerns about the patient’s mental health, refer to the on-call psychiatrist, psychiatric liaison nurse or mental health team. If there are any signs of substance use or misuse, discuss with the patient the health body policy on the use of substances. Refer the patient to the substance misuse team, if appropriate. If appropriate, set boundaries with patient and employ the use of a behaviour agreement (see appendix 2 for template). If there are any organic or other physical health concerns, refer to the appropriate member of the MDT. Explain policy regarding prescribed medication.</td>
</tr>
</tbody>
</table>
|   | Assess whether patient has any previous known episodes of violence and/or abuse, including any trigger factors or antecedents such as a recent bereavement. | • Establish from medical records/nursing notes whether patient has had any previous episodes of violence and/or abuse against NHS staff.  
• When engaging with the patient, be alert to any information that they disclose about incidents in their personal life that may have precipitated previous violent behaviour, such as medical/psychiatric diagnosis, change to marital status, bereavement, redundancy etc. This can be achieved through general conversation rather than a direct questioning process.  
• Ensure that all staff, including the multi-disciplinary team, new staff and agency/bank staff, are aware of patient's history and how to care for them in a safe manner.  
• Ensure that all staff are aware of what to do in the event of a violent or abusive incident, and publicise the locally adapted 'Suggested management of a violent/abuse incident' flowchart demonstrated in appendix 3.  
• Observe for warning signs and triggers, and manage appropriately on the scale of de-escalation and resolution to calling for assistance.  
• Promote an environment that provides safety and reduces agitation. | Ongoing |
|---|---|---|---|
| 7 | If known history of violence or abusive behaviour, establish whether there is a history of using weapons, hostage taking etc. | • Ensure that all staff, including the multi-disciplinary team, new staff and agency/bank staff, are aware of patient's history and how to care for them in a safe manner.  
• Ensure that all staff are aware of what to do in the event of a violent or abusive incident, and publicise the locally adapted 'Suggested management of a violent/abuse incident' flowchart demonstrated in appendix 3.  
• Observe for warning signs and triggers, and manage appropriately on the scale of de-escalation and resolution to calling for assistance. | Ongoing |
<p>| | | |</p>
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</table>
| 8 | As regards any previous episodes of violence or abusive behaviour, establish the following if possible: how it was managed; which interventions were successful and which were not; how long the episode of violence or abusive behaviour lasted; if medication was used to resolve the situation; if the police were involved; and what sanctions, if any, were applied. | • If in previous episodes of violence, particular interventions worked, review these for application locally. If particular interventions did not work, review these for lessons to be learned and ensure that all of the multi-disciplinary team, new staff and agency and bank staff are aware of these.  
• Observe for warning signs and triggers, and manage appropriately on the scale of de-escalation and resolution to calling for assistance. | Ongoing |
| 9 | Where possible, use appropriate advanced directives\(^2\) determined by the patient. | • Staff may wish to consider previous incidents recorded and decide whether it would be helpful to discuss known trigger factors and any preferred intervention with the patient.  
• Staff may wish to consult their mental health colleagues for advice before engaging in such a discussion with the patient.  
• Ensure that any advanced directives are communicated to all staff caring for the patient. | As required |

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\(^2\) An advanced directive is a document that contains the instructions of a patient, setting out their requests in the event of a relapse of a condition or an incident of disturbed/violent behaviour etc. It sets out the treatment that they do not want to receive and any treatment preferences that they may have in the event that they become violent. It also contains the names of people whom they wish to be contacted and any other personal arrangement that they wish to be made.
## Report of a Physical Assault on NHS Staff

**Business Services Authority**

**Security Management Service**

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**Your reference**

**Is this incident linked to another PARS report?**

**PARS reference**

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This form is to be used for the reporting of all physical assaults against NHS staff and professionals that fall within the single definition of physical assault as detailed in Secretary of State Directions on tackling violence issued in Nov 2003.

The definition is: "The intentional application of force against the person of another without lawful justification, resulting in physical injury or personal discomfort."

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**Name of trust:**

**Contact tel. number:**

**LSMS of trust (or SMD if no LSMS in post)**

**Address of trust:**

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**IMPORTANT – MUST BE COMPLETED**

Based on appropriate clinical advice, is this assault considered likely to have been unintentional, as the assailant did not know what they were doing or did not know that what they were doing was wrong due to medical illness, mental ill health, a severe learning disability or treatment administered? **YES** □ **NO** □

**Incident date (dd/mm/yy)**

**Incident time (hh:mm)**

Did the assault occur during the restraint of the assailant for reasons not connected with this assault? (e.g. to administer medication) **YES** □ **NO** □

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**Site address where assault took place (full address including postcode)**

**Specific location of assault within the site (e.g. Ward 1, A&E, patients’ kitchen, etc)**

---

**PERSON ASSAULTED**

**Last name**

**First name**

**Employment title**

**Date of birth (dd/mm/yy)**

**Male** □ **Female** □

**Work tel.**

**Other tel.**

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**Injuries sustained**

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**Treatment received**

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**Does the victim wish to pursue the matter via the police or NHS SMS Legal Protection Unit?** **Yes** □ **No** □
Membership of the working group

Andy Thompson  
Local Security Management Specialist, Hull and East Yorkshire Hospitals NHS Trust

Avril Redmond  
Chair of RCN Nephrology Nurses Forum

Caroline McGreary  
Matron for Haemodialysis, Barts and The London NHS Trust

Chris Boseley  
Safety and Security Manager, East and North Hertfordshire NHS Trust

Chris Spence  
Local Security Management Specialist, South Tees Hospital NHS Trust

Christine Beasley  
Chief Nursing Officer, Department of Health

Dominic Mullan  
Local Security Management Specialist, South Leeds PCT

Gayle Ridge  
Research Fellow, City University/Barts and The London NHS Trust

Gemma Fry  
Palliative Care Unit, Royal Marsden Hospital NHS Trust

Gerard McEvilly  
Head of Legal Protection Unit, NHS Security Management Service (until December 2006)

Ian Taylor  
Local Security Management Specialist, Kings College Hospital, NHS Trust

Janet Murat  
Clinical Nurse Specialist HIV, Tower Hamlets PCT

Janice Sigsworth  
Deputy Chief Nursing Officer, Professional Leadership Team, Department of Health

John Sedgewick  
Programmes Director, Multi Professional Programmes, School of Health & Social Care, University of Teesside/RCN Nephrology Forum member

John Thomson  
Senior Legal Case Officer, NHS Security Management Service

Julia Jones  
Senior Research Fellow, City University/Barts and The London NHS Trust

Julie Baker  
Network Palliative Care Project Manager, North East London Cancer Network

Katherine Fenton  
Director of Nursing and Quality, Barts and The London NHS Trust (until October 2006)

Martin Raftery  
Clinical Director for Cardiac & Renal, Barts and The London NHS Trust

Dr Neil Ashman  
Renal Physician, Barts and The London NHS Trust

Pamela Workman  
Security Manager, Hammersmith Hospitals NHS Trust

Rick Tucker  
Head of Security Management – Mental Health and Learning Disability Services, NHS Security Management Service

Rita Joshi  
Senior Policy Officer, NHS Security Management Service
Robert Dunn  National Kidney Federation
Stewart Russell  Local Security Management Specialist, Barts and The London NHS Trust
Susan Wheeler  Education Lead for Haemodialysis, Barts and The London NHS Trust
Tom Webster  Local Security Management Specialist, Nottinghamshire County PCT and Sherwood Forest Hospitals Foundation Trust

Secretariat
Susan Frith  Deputy Head of Security Management, NHS Security Management Service
Lorraine Harris  National Secondary Care Senior Manager, NHS Security Management Service

Professionals/bodies consulted
Alistair McNicol  West London Mental Health NHS Trust
Andrew Bowker  Health and Safety Executive
Anthony Crumpton  Mersey Care NHS Trust
Bill Chilcott  South East Coast Ambulance Service NHS Trust
Bill Parkinson  Northern Lincolnshire and Goole Hospitals NHS Trust
Christopher Bartram  Bedford Hospital NHS Trust
Christopher Stanger  South West London and St George’s Mental Health NHS Trust
Daniel Smith  North Staffordshire Combined Healthcare NHS Trust
David Rose  NHS Litigation Authority
Elaine Stevenson  National Patient Safety Agency
Frances Healey  National Patient Safety Agency
Joe Delaney  South Essex Partnership NHS Trust
Kim Sunley  Society of Radiographers
Lucy Warner  NHS Clinical Governance Support Team
Mark Sheldon  Coventry and Warwickshire Partnership NHS Trust
Peter Finch  Sandwell and West Birmingham Hospitals NHS Trust
Robert Baughn  Unison
Steve Lutener  Pharmaceutical Services Negotiating Committee