NHS Resolution

Learning from workplace violence claims within the NHS

A thematic review

Advise / Resolve / Learn

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Foreword

This important report, produced by NHS Resolution in collaboration with the Social Partnership Forum and NHS England amongst others, reveals the higher-than-average risk of experiencing workplace violence for those working within the NHS. To protect our staff and clinicians, who together represent one of the most valuable assets of the NHS, and to ensure that we are able to continue providing high quality, safe care for patients, every effort must be made to prevent and reduce workplace violence.

Through the unique lens of NHS Resolution's claims data, this report highlights the significant physical and psychological injuries NHS staff endure when they experience workplace violence. As well as the significant personal impact, staff in these circumstances will often experience financial losses due to missing work as a result of injuries suffered. In addition to these individual costs, from an organisational perspective there are wider impacts such as absenteeism, a reduction in staff retention and associated financial costs.

The findings of this report align with the existing evidence that providers of NHS-funded care should give further attention to the prevention and reduction of workplace violence to ensure compliance with relevant legislation and NHS England's Violence Prevention Reduction Standard.[5,15] This report has been produced to complement wider work to help prevent and reduce workplace violence faced by healthcare staff. We believe these ongoing efforts would be maximised by the development of an NHS National Violence Reduction Strategy.

In March 2023, NHSR published our *Being fair 2* report which aims to promote the value of a person-centred workplace that is compassionate, safe and fair. We encourage everyone involved in the provision of healthcare to adopt these principles and ensure that staff affected by workplace violence are supported effectively and compassionately. This report emphasises the vital role leadership plays in achieving this.

We are grateful to all colleagues involved in the production of this report, and particularly for the input of our advisory group who have provided invaluable support. We hope this report will help to influence approaches to tackling workplace violence, ultimately helping to reduce and prevent these incidents within the NHS, with far-reaching impacts for staff, NHS organisations, and patients.

Megan Bidder
Director of Safety and Learning

Executive summary

In 2020, the Health and Safety Executive published its Violence at Work Statistics report. It highlighted that healthcare professionals encounter a higher-than-average risk of workplace violence. Healthcare staff who have experienced workplace violence may choose to pursue a claim to compensate them for the personal and financial losses they have encountered during the course of their work. NHS Resolution's Liabilities to Third Parties Scheme[a] (LTPS) manages such claims.

The purpose of this thematic review is specifically to share insights from claims that have been brought by NHS staff who have experienced workplace violence exhibited by patients in their care. In collaboration with the project advisory group who have supported the development of this report, our ambition is that these insights will help inform future improvements that not only lead to a reduction in workplace violence within the NHS, but also enhance organisational response to all those affected when workplace violence does occur.

NHS Resolution has undertaken an analysis of claims brought by healthcare staff who have experienced workplace violence between 2010/11 and 2019/20.

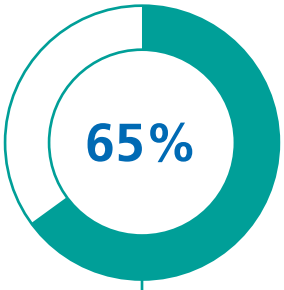
We identified relevant claims from our database known as the Claims Management System. A total of 5,287 claims, between the fiscal years 2010/11 and 2019/20, were identified for inclusion in the quantitative analysis of this thematic review. These claims represented 13% of all claims brought during the financial years of 2010/11 and 2019/20. For the qualitative analysis, a random sample of 40 claims were thematically analysed in detail. Only claims brought after 31 December 2015 were included in this element of the thematic review.

Summary of key findings

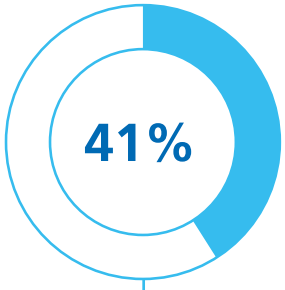
Of the 5,287 claims included in the quantitative analysis, 4,674 were closed. We found the total cost of the closed claims to be £61.4 million. We found 2,941 (63%) to be unsuccessful with no damages paid and 1,733 (37%) to be successful with damages paid. The total amount of damages paid for the closed successful claims was £31,250,887.83.

[a] Our Liabilities to Third Parties Scheme (LTPS) typically covers employers' and public liability claims from NHS staff, patients and members of the public. These range from straightforward slips and trips to serious workplace manual handling, bullying and stress claims. LTPS covers claims arising from breaches of the Human Rights Act, the Data Protection Act and the Defective Premises Act, as well as defamation, unlawful detention and professional negligence claims. LTPS also extends to cover the personal liabilities of the members of NHS boards, including non-executive directors. Personal injury cover is unlimited in value and there is no limit on the number of claims members may make in any membership year.

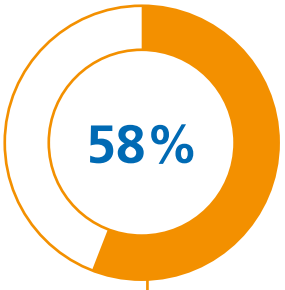
Our analysis of successful claims found that:



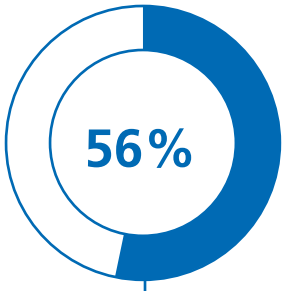
65% of those pursuing a claim for workplace violence were female and 35% were male.



41% of those pursuing a claim for workplace violence worked in a healthcare support role[b].



Mental health settings accounted for the highest volume of workplace violence in 58% of the successful claims.



Orthopaedic injuries were most commonly reported and accounted for 56% of successful claims.

- The quality and accuracy of risk assessments were noted to be inadequate and did not acknowledge escalating risk of violence.
- Staffing levels often did not include an adequate number of people who had completed training in the prevention and management of workplace violence.
- Organisational policies and procedures on the prevention and management of workplace violence were not always in place.
- Organisational response and support to members of staff who have experienced workplace violence is variable.

We will discuss these findings and themes in more detail in the next section of this report. Please note that some readers may find the content of this report upsetting.

[b] Examples of healthcare support roles include healthcare assistants and clinical support workers.

Background

In this section we provide some background to NHS Resolution, and how our work aligns with ongoing national efforts to prevent, reduce and respond to issues arising from our work on managing claims on behalf of the NHS in England. We discuss the approach adopted throughout this report to describe and define workplace violence. We report the current incidence of workplace violence in healthcare and set out the role of current policy and legislation in preventing, reducing and responding to workplace violence.

NHS Resolution

NHS Resolution, formerly known as the NHS Litigation Authority (NHSLA), was established in 1995 as a special health authority, providing not-for-profit indemnity cover for compensation claims against the NHS.

The NHS Resolution strategy to 2025, *Advise, resolve and learn*, includes a focus on sharing data and insights as a catalyst for improvements that benefit patients, the healthcare and justice systems. Our Safety and Learning service plays a key role in achieving this strategic priority by bringing together key partners working together to target safety activity, share learning across the system and drive improvement.

In March 2023, NHS Resolution published *Being fair 2*[2], which aims to promote the value of a person-centred workplace that is compassionate, safe and fair, particularly when care in the NHS goes wrong. The report sets out the benefits of adopting a more reflective and fair approach to supporting staff when harm does occur and includes a Just and Learning Culture Charter which healthcare organisations are encouraged to adopt. The key role that healthcare leaders have in improving safety, including the importance of good relationships between leaders and their teams, is highlighted in the *Being fair 2* report.

Through this thematic review, an opportunity exists to consider the vital role leadership has in the prevention and reduction of workplace violence and the response of healthcare providers when workplace violence does occur within the NHS.

Defining and describing workplace violence

The Health and Safety Executive (HSE) defines work-related violence occurring within the healthcare setting as being *any incident in which a person is abused, threatened or assaulted in circumstances related to their work. For the purposes of this thematic review and the context within which the issue of workplace violence is being considered, the HSE definition has been adopted*[3].

NHS England's Violence Prevention Reduction (VPR) Standard[4] describes the impact language can have on those we engage with, especially those who have gone through trauma at some point in their lives. This thematic review aligns with the language used with the NHS England VPR standard and refers to 'individuals who have experienced violence' and 'individuals who have exhibited violent behaviour'.

Incidence and impact of workplace violence across healthcare

In 2020, the HSE published its Violence at Work Statistics report, which reported that healthcare professionals encounter a higher-than-average risk of workplace violence, at 3.9%. The report also stated that "these professions have consistently had higher than average risk rates over the last number of years"[1].

The 2023 NHS Staff Survey[5] showed 13.69% of NHS staff experienced physical violence from members of the public and patients. Of the staff who had experienced physical violence, 73.62% said that they or a colleague reported this through their organisations reporting systems.

Current policy and legislation

Current policy and legislation is aimed at preventing, reducing and responding to workplace violence in healthcare. The NHS Constitution for England[6] describes the extensive legal rights, embodied in general employment and discrimination law, that help to ensure staff have healthy and safe working conditions and an environment free from harassment, bullying or violence. This is reflected in the NHS People Plan[7] which articulates the statutory duty of care incumbent upon NHS leaders to prevent and control violence in the workplace, so that staff never feel fearful or apprehensive about coming to work. In 2020, NHS England launched the Violence Prevention and Reduction Standard[5], which aims to create a safe workplace through risk-based measures and partnerships. From 2022, all organisations operating under the NHS Standard Contract must use all reasonable endeavours to implement the Violence Prevention and Reduction Standard as detailed under General Clause 5[8].

The legal requirements placed upon the NHS in England in relation to workplace violence are broad ranging and fall mostly within the health and safety legislation. The overarching Health and Safety at Work Act 1974, specifically section 2 (1)requires that "it shall be the duty of every employer to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all his employees"[9]. Failure to comply with the requirements under the legislation is a criminal offence that often leads to action by the enforcing authorities such as the HSE. This can result in prosecution, fines and reputational damage to an organisation via adverse media attention.

There are wider financial consequences of non-compliance, including costs due to sickness absence, staff attrition and claims for compensation. As this report demonstrates, those experiencing violence in the workplace may pursue a claim to compensate them for the significant personal harm and financial losses they have suffered as a result.

Methodology

To undertake this review of workplace violence claims brought against the NHS in England, we extracted and analysed quantitative and qualitative data to identify themes emerging within claims and evaluate these to inform the areas of future focus emerging from this report.

We identified claims concerning workplace violence brought under the LTPS between the financial years 2010/11 and 2019/20 from NHS Resolution's Claims Management System.

We reviewed each claim to ensure that those considered as part of this review related to a member of healthcare staff who had experienced violence in the workplace.

We undertook a quantitative analysis of the included claims to identify the trends and themes. We considered closed claims only where the costs associated with included claims were determined from the analysis. This is because the costs associated with open claims are highly likely to change.

To reach data saturation, we estimated that between 15 and 60 items (e.g. interviews, cases, etc.) will need to be analysed[10]. 40 claims selected at random for the qualitative analysis proved to be an adequate sample group as no new additional insights were being identified. The 40 claims analysed only included claims brought after 31 December 2015.

This analysis included reviewing letters of claim, incident reports and investigation reports, and charting the themes emerging from the information existing within this unique data set. We evaluated themes emerging from both the quantitative and qualitative analysis and used them to inform the areas for future focus and consideration proposed for discussion with the project advisory group.

Limitations of the analysis

There are a number of limitations to this report. NHS Resolution covers trusts in England only and direct comparison with other devolved nations may not be helpful (although they are believed to have similar themes), particularly with different legal systems.

Our Claims Management System was primarily designed for managing claims, rather than for enabling the NHS to learn from compensation claims. Protected characteristic data are not coded for the purposes of management of the claim except sex and age. Claims are coded by claims managers, and many codes relate to legal process rather than individual outcome, which can restrict analysis.

It is important to highlight that claims data is not representative of all incidents that occur within healthcare (WHO, 2005)[11]. While claims analysis can provide a perspective on compensation, this lens can provide a narrow, historical view of adverse incidents and does not readily reveal the good practice taking place. However, it is an important lens for the identification of remediable errors and system learning.

Information governance

This was a retrospective anonymised review using routinely collected data from the NHS Resolution claims database.

Research ethics committee approval was not required because this was a review of routinely collected data. All personal data held and used by NHS Resolution is processed in accordance with the UK implementation of the GDPR. Staff involved in this work (and all those who work for NHS Resolution more generally) are subject to confidentiality obligations. Part of NHS Resolution's remit is to learn from the information held for claims and to disseminate this learning as widely as possible across the NHS to improve patient safety and reduce harm. This report has used the data held for this purpose and as far as possible, the review has reduced the use of identifiable material to a minimum during the research process.

Results

The initial data extraction took place in February 2021 and identified 5,689 potentially relevant claims that were brought between the financial years 2010/11 and 2019/20 under the LTPS. Of the claims initially identified, 402 did not concern a member of healthcare staff who had experienced violence in the workplace so were excluded from the data set. A total of 5,287 claims were included in the quantitative analysis of this thematic review. The claims represented 13% of all claims brought between the financial years 2010/11 and 2019/20. The number of claims concerning workplace violence brought by healthcare staff increased by 43% between 2010/11 and 2019/20.

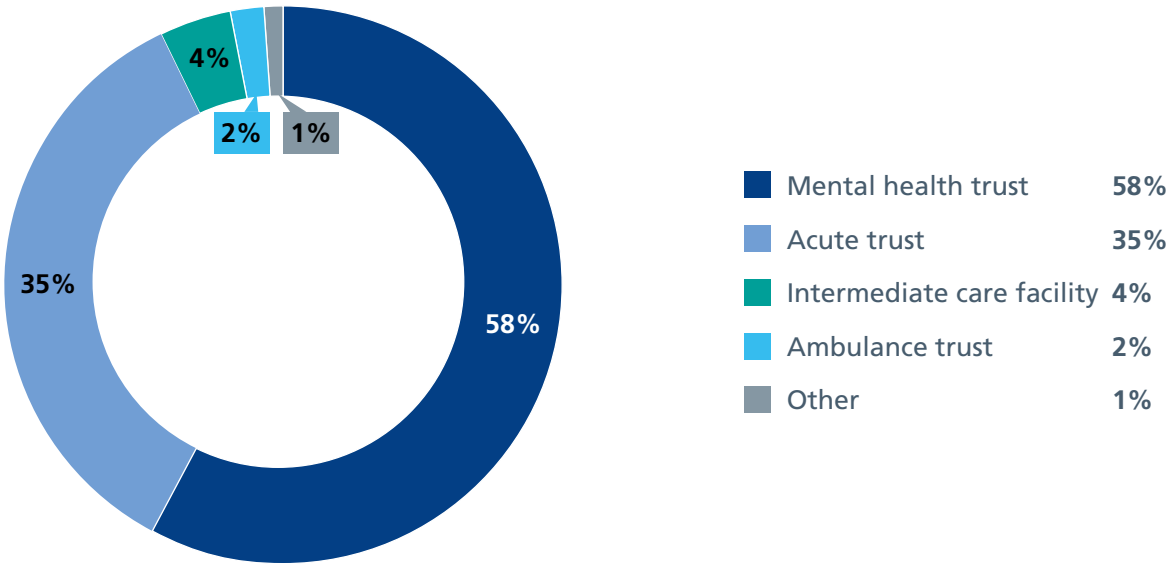
Financial analysis

Of the 5,287 claims included in the quantitative analysis, 4,674 were closed. The total cost of closed claims was £61.4 million. Of the closed claims, 2,941 (63%) were unsuccessful as no admissions were made. Admissions were not made as there was evidence of compliance with relevant policy and legislation. 1,733 (37%) were successful as admissions were made resulting in damages[c] being paid. The total value of damages paid for the closed successful claims was £31.2 million. The average number of days between the date of incident and the date the claim was submitted was 264 days. The average number of days between the date the claim was submitted and the date the claim was settled[d] was 626 days.

Organisational analysis

We reviewed the successful claims and classified them into types of organisation where the incident occurred. As Figure 1 demonstrates, mental health settings accounted for the highest volume of workplace violence with 1,008 claims (58%).

Figure 1: Organisational analysis of successful claims brought by healthcare staff who have experienced workplace violence



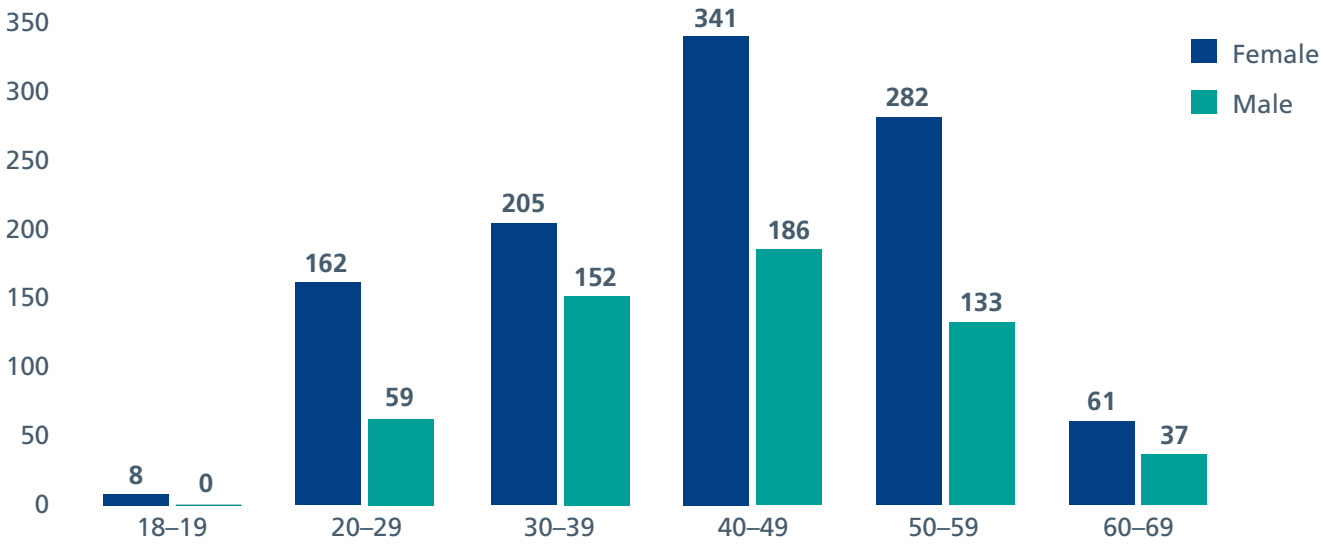
[c] Damages is the amount of compensation to claimants which includes both the expected amounts to be paid and actual amounts that have been paid to date.

[d] Settled claims are those where there has been a settlement or court order in relation to damages, for either nil or an amount for payment.

Workforce analysis

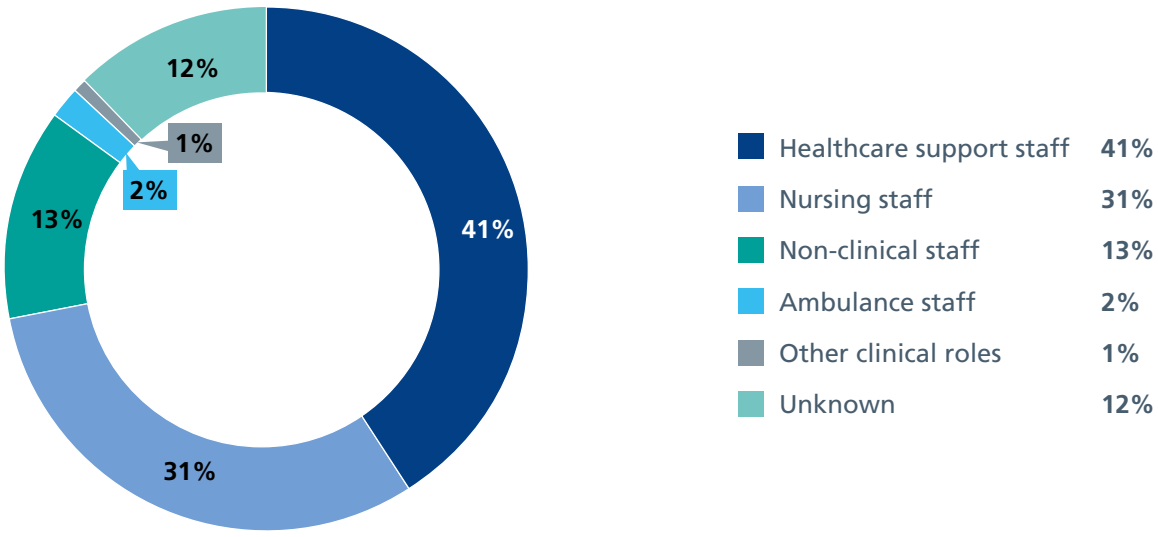
Of the 1,733 successful claims identified, 1,127 (65%) of those pursuing a claim for workplace violence were female and 606 (35%) were male. As illustrated in Figure 2, the greatest number of claims were made by individuals between the age range of 40 and 49; this was the same for both male and female staff members pursuing a claim for workplace violence.

Figure 2: Age and sex of staff who have experienced workplace violence and successfully pursued a claim



We undertook further analysis of the successful claims to determine, where possible, the role of healthcare staff pursuing the claim. Our findings from this further analysis are summarised in Figure 3. A key observation from this analysis is that healthcare support staff represented 41% of successful claims brought.

Figure 3: Role of healthcare staff who have successfully pursued a claim for workplace violence

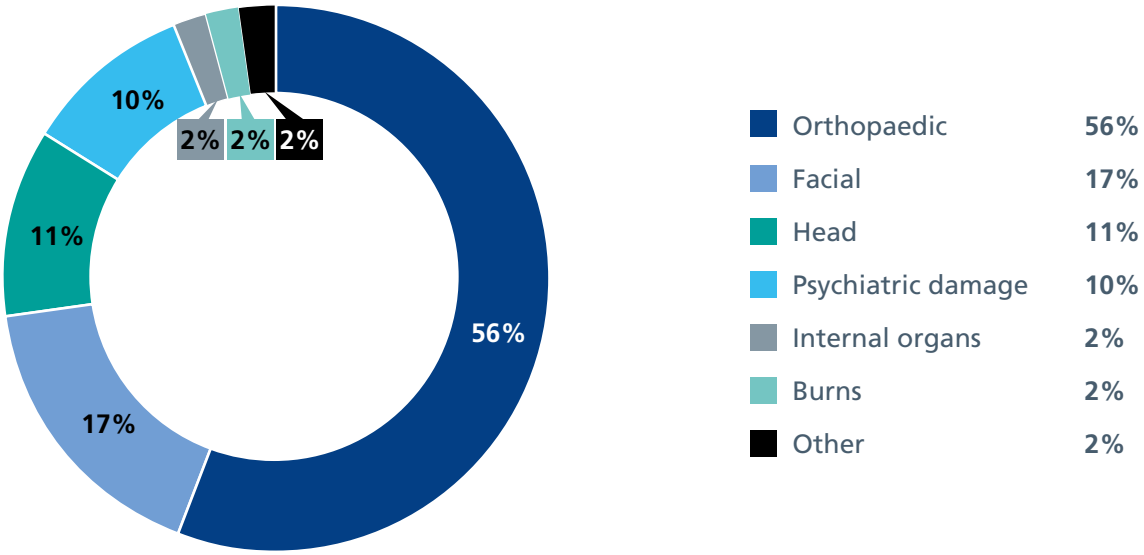


Results Cont'd

Injuries sustained because of workplace violence

Figure 4 summarises the type of injury sustained by healthcare staff who have experienced workplace violence and are pursuing a claim for compensation. Orthopaedic injuries were most commonly reported and accounted for 3,086 (58%) of claims. For an individual claimant, these could include multiple fractures including long-bone fractures. Facial injuries accounted for 891 (17%) claims, head injuries accounted for 594 (11%) claims and psychiatric damage accounted for 390 (7%) claims.

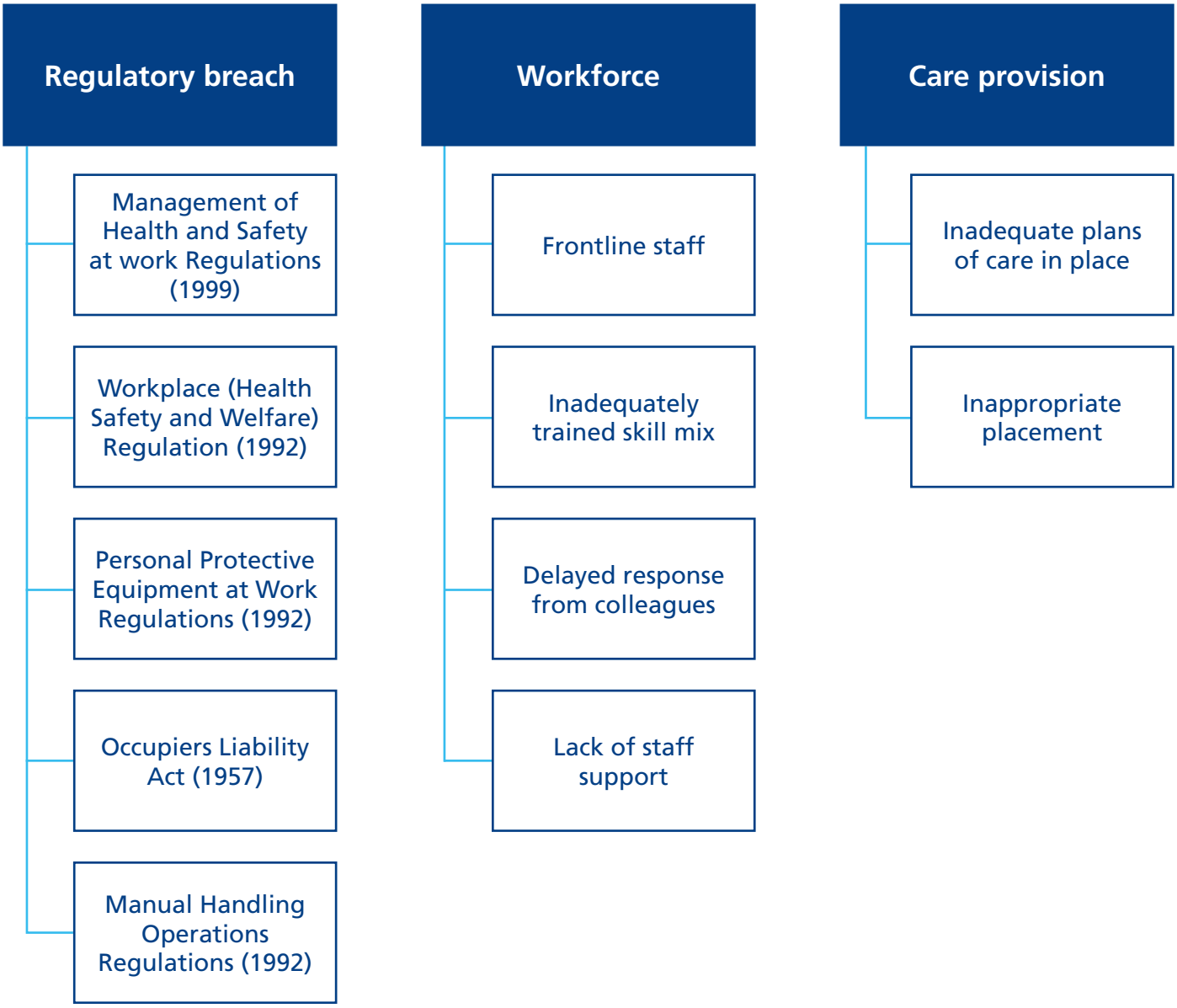
Figure 4: Type of injury sustained by healthcare staff who have successfully pursued a claim for workplace violence



Thematic analysis

Of the 5,287 claims we reviewed, we analysed a sample of 40 successful closed claims in detail. As mental health trusts accounted for the highest proportion of successful claims (58%), 20 of the claims reviewed arose from this type of trust. The other 20 claims concerned acute trusts which accounted for 35% of successful claims. For each of these 40 claims, we charted the key theme emerging to determine which occurred the most frequently; an overview of which is shown in Figure 5. It is important to note that analysis of these claims will not necessarily be representative of all successful claims.

Figure 5: Most identified themes identified in the qualitative analysis of 40 successful claims



Discussion

Regulatory breach

A breach of the Management of Health and Safety at Work Regulations (1999)[12] was cited in each of the 40 claims; the most frequently breached regulations were 3, 4, 5 and 13. Regulation 3 requires employers to make a suitable and sufficient risk assessment of the risks to the health and safety of their employees to which they are exposed while they are at work. The Regulation also requires any assessment to be reviewed by the employer if there is a reason to suspect it is no longer valid or there has been a significant change in the matters to which it relates. A breach of Regulation 3 was cited the most frequently (90%).

This finding aligns with those of the HSE which, between 2018 and 2022, carried out a series of inspections across 60 NHS trusts in Great Britain to assess the management and control of violence and aggression in the NHS[13]. In 60% of trusts inspected, the laws aimed at preventing and reducing workplace violence were contravened. A common feature where contraventions were seen included the failure of NHS employers to conduct suitable and sufficient risk assessments to control the risk to employees of experiencing workplace violence. The issues identified included risk assessments being too generic with high-risk areas not being identified, assessments not including non-clinical workers who were exposed to the risk and inconsistencies in the approach to risk assessment across the same organisation.

In 2015, the National Institute of Clinical Excellence (NICE) updated its guidance on the short-term management of violence and aggression in mental health, health and community settings. Approaches to assessing and managing the risk of violence and aggression are outlined within the guidance, including standardised tools to support risk reduction and the requirement to frequently review risk assessments and risk management plans [NG10][14].

Despite the existence of this guidance, in the individual and environmental risk assessments reviewed as part of the analysis, we observed that there was no standardised approach to assessing the risk of violence, and the wider considerations outlined in NG10 were not consistently appraised. We observed a variance in tools used to support risk assessments of different approaches. For example, some risk assessments were based on a singular rating of risk whereas others were based on a rating of risk involving multiple factors. Where risk assessments were reviewed frequently, the level of detail diminished with an increasing tendency to use the phrase ‘unknown’.

In some cases, global risk ratings appeared to be underrated, i.e. the score was lower than expected when comparing the narrative information (for example, escalating risk of violence) to the documents scoring matrix. Risks were described broadly, for example as ‘risk to service users or staff secondary to violence and aggression by service users’, without identifying the specific factors that were driving the existence of the risk, for example a previous history of exhibiting violent behaviours. It is possible that this resulted in the cumulating risk of violence not being recognised, communicated or mitigated against.


PATIENT MEDICA
Patient's Name
Date of Birth
Problems with Anesthesia?
YES
NO
If yes, explain
Age
Weight
Height
Current Complaints
Allergies / Difficulties with Medication & Reaction
None
Latex
Metal / Jewelry
Are you:
Right handed
Date of Last Tetanus
Current Medication
No Illnesses
AIDS / HIV
Angina
Asthma
Arthritis
Bladder
Bleeding
Bronchitis
Bursitis
Cancer
Do you smoke tob
Do you drink alcohol
Do you take drugs?
Marital Status:
Employment: (Type)
FAMILY HISTO
No Diseases
Asthma
Arthritis
Cancer
Diabetes
Excessive Bleeding
Heart Disease
High E
Kidney
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Stroke
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Tendonitis
Tuberculosis
Ulcers
Varicose Veins
Venereal Disease
Other
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Discussion Cont'd

Regulation 4 of the Management of Health and Safety at Work Regulations (1999)[10] concerns the implementation of preventative and protective measures. Issues noted in the thematic review pertinent to this regulation related to the failure to ensure effective alert systems were in place. A breach of Regulation 4 was cited in 40% of the 40 claims reviewed in depth. In these claims we noted an absence of alarm systems to alert others, for example in reception areas. In some claims, staff had been issued with personal alarms, but these did not work when activated. On occasion, staff were reliant on using their own mobile devices to call for assistance.

Regulation 5 of the Management of Health and Safety at Work Regulations (1999)[10] requires employers to ensure the effective planning, organisation, control, monitoring and review of the preventative and protective measures required by Regulation 4 of the Act. A breach of Regulation 5 was cited in 85% of the 40 claims reviewed in depth and concerned the failure to have adequate policies and strategies in place to prevent the occurrence of workplace violence. This breach also relates to Regulation 5 of the Workplace (Health, Safety and Welfare) Regulations (1992)[15], the Personal Protective Equipment at Work Regulations (1992)[16] and the Provision and Use of Work Equipment Regulations (1998)[17], which were all cited within the claims reviewed. These regulations concern the maintenance of the workplace, and of equipment, devices and systems, ensuring the suitable provision of personal protective equipment and ensuring that equipment provided is suitable for the intended use.

Regulation 13 of the Management of Health and Safety at Work Regulations (1999)[10] requires every employer to ensure that employees are provided with adequate health and safety training. A breach of this regulation was cited in 60% of the 40 claims reviewed in depth and is linked to Regulation 4 of the Manual Handling Operation Regulations (1992)[10]. This regulation outlines the duty of employers to avoid the need for their employees to undertake manual handling activity and, where unavoidable, to undertake a suitable and sufficient assessment of all such manual handling operations and reduce the risk of injury.

In 15% of the claims reviewed, a further Regulation that was cited as having been breached was the Occupiers Liability Act (1957)[19]. Section 2 of the Occupier's Liability Act outlines the duty of care premise owners have to those attending their premises including that they will be reasonably safe when using the premises. For this report, this relates to the NHS workforce attending their place of employment.

Workforce

Of the 40 successful claims reviewed, 90% were brought by those involved in the delivery of frontline care, the highest proportion of whom were Healthcare Assistants (60%). Claims brought by agency staff accounted for 15% of the 40 successful claims reviewed.

Of the claims reviewed, 45% cited the staffing skill mix as being inadequate. For example, staff had not undergone an appropriate induction or undertaken training on the prevention and management of workplace violence, which relates to the thematic analysis findings. A delay in response was reported in 20% of claims, from colleagues who may not have received the appropriate training so did not feel able to respond. A delay in response may also be attributable to the time of day the episode of workplace violence occurred; 43% took place during unsocial hours, i.e. at a weekend or between the hours of 8pm and 7am.

The Restraint Reduction Network (RRN) Training Standards have been developed to underpin training provided to staff who support people with mental health conditions, dementia and learning disabilities, and autism. The standards are mandatory for all training delivered by specialist NHS commissioned services in England that contains a restrictive component. Since the implementation of the standard in April 2021, the Care Quality Commission (CQC) expects services across healthcare to provide certified training that complies with the RRN Training Standards.

Of the claims reviewed, 13% cited an absence of support for those affected by workplace violence. We noted that documents included the impact and reaction of the individual who exhibited violent behaviour but not of the staff who were exposed to violence. Following a workplace violence incident, where an investigation took place there was little documentation of attention given to the organisational response immediately after a member of healthcare staff had experienced workplace violence. Information submitted as part of the claims process indicated that staff were often expected to complete their shift, before driving themselves to hospital to seek treatment for their injuries, which in some cases were long-bone fractures. There was little evidence that consideration was given to the possible trauma associated with this working pattern, or of the psychological impacts of experiencing violence at work. Concerns around loss of earnings were cited in the claims and staff were not aware of the NHS Injury Allowance that they were entitled to. There was minimal evidence of organisations having a clear protocol for ensuring an adequate response is provided to staff following a violent incident.

Section 2 of the Health and Safety at Work Act 1974[8] outlines the general duty of care that organisations have to ensure the health, safety and welfare at work of all its employees. This includes ensuring that they are adequately and appropriately supported should they experience workplace violence. The NICE guidance on the short-term management of violence and aggression in mental health, health and community settings [NG10][14] includes guidance on post-incident support following an episode of violence in inpatient psychiatric settings. While the recommendations specifically apply to an episode of violence that involves the use of a restrictive intervention to manage violence or aggression[c], they still have the potential to inform local policies outlining appropriate responses to workplace violence occurring in a broader range of circumstances and settings.

Discussion Cont'd

Care provision

As Figure 1 demonstrates, mental health settings accounted for the highest volume of workplace violence with 1,008 claims (58%). This finding aligns with the Royal College of Nursing's 2021 Employment Survey[20] which identified that respondents working in mental health settings were most likely to report having experienced both physical and verbal abuse.

In 18% of the claims reviewed, inappropriate patient placement was cited as a contributory factor, e.g. the service user met psychiatric intensive care unit criteria but was not transferred to that clinical service. The Royal College of Nursing's 2021 Employment Survey[20] found that just under half of respondents felt that physical and verbal abuse was linked to health or personal problems, often where a patient may lack capacity due to dementia or a mental health problem. Detail on patient history is not necessarily disclosed as part of the claims process but where such information was included, it was apparent that those exhibiting violent behaviour were acutely unwell, e.g. with mental illness, delirium or dementia. The absence of individual healthcare plans that met the needs of the patient and reduced the risk of violent behaviour were cited within 15% of the 40 claims.

In 2014, the Department of Health published *Positive and Proactive Care*[19], which provides a framework to support the development of ways of delivering care and support that better meet people's needs and that enhance quality of life. It recognises that therapeutic environments are most effective for promoting both physical and emotional wellness and that restrictive interventions should only be used where there is a real possibility of harm to the person or to staff, the public or others. The guidance provides clear actions for improving care through individualised support plans, which must be implemented for those known to be at risk of being exposed to restrictive interventions. Should a restrictive intervention be required, the guidance outlines the considerations that must be made to ensure that a restrictive intervention is appropriate and proportionate.

Conclusion

In this report we have outlined the financial cost of negligence claims brought by NHS staff who have experienced workplace violence. Importantly, we have highlighted the physical and psychological injuries staff endure when they experience workplace violence. Staff will also often experience financial losses due to not being able to work because of injuries suffered.

All providers of NHS-funded services are legally obligated to ensure they are compliant with relevant health and safety legislation that supports the prevention and reduction of workplace violence. Under the NHS Standard Contract, all providers of NHS-funded services are required to review their status against the VPR Standard and provide board-level assurance that the Standard has been achieved at a minimum of six-monthly intervals.

This analysis of claims brought by healthcare staff who have experienced workplace violence aligns with the existing evidence that providers of NHS-funded care should give further attention to the prevention and reduction of workplace violence to ensure compliance with relevant legislation and the VPR Standard.[4,13]

Adopting the principles outlined by the VPR Standard can support providers of NHS-funded care to effectively achieve compliance.

Focus areas

Informed by this analysis and the expertise of the project advisory group, the following areas for future focus were identified.

Ensuring suitable and sufficient risk assessments

Suitable and sufficient risk assessments should be undertaken, reviewed regularly and updated when required. Where risk assessments concern the general working environment, consideration should be given to the environment including determining what alarm and surveillance systems are required to protect staff and support the prevention and reduction of workplace violence Consideration should also be given to the experience and skill mix of staff.

Risk assessments should also consider the patient clinical condition. Clinicians should be supported to take a standardised approach to assessing the individual risk of violence by promoting use of NG10[14] recommended evidence-based tools (the Brøset Violence Checklist (BVC) or the Dynamic Appraisal of Situational Aggression (DASA-IV)) via local violence prevention and reduction policies. All risk assessments should be reviewed regularly and updated where required.

Training

Providers of NHS-funded services should facilitate evidence-based, collaborative, multi-professional training focusing on the prevention and reduction of workplace violence. This includes ensuring the training is certified and complies with the RRN Training Standards. Consideration should be given to the roles of staff, who, if they interact with patients and the public (in person and via telephone), should receive Conflict Resolution Training. All staff should be released to attend mandatory training in relation to violence and aggression in working time and be provided with shift cover so non-attendance is prevented. Special consideration should also be given to ensuring the provision of appropriate training for agency staff and students on clinical placement.

Workforce

In addition to staffing levels, attention should be given to ensuring that the skills mix is optimised and adequate. Specific consideration should be given to the training and induction of agency staff, locum staff and students on clinical placements who may be at greater risk from experiencing workplace violence. Effective working relationships and clear lines of communication should exist between host employers, agencies and Higher Education Institutions.

Staff support

When staff experience workplace violence, a suitable package of support should be available and should include immediate and long-term physical, emotional and financial support, the details of which should also be held in local violence prevention and reduction policies. Managers should receive relevant training to ensure such packages of support are delivered effectively.

Development, implementation and evaluation of local policies

To ensure adequate risk assessments are undertaken and effective training is delivered, robust local policies and procedures must be developed in consultation with local trade unions and the wider healthcare system. Policies and procedures require regular review, and should include guidance on immediate response to violent incidents, approaches to maintaining a safe environment (including details of alarm systems, how to use them and their maintenance), roles and responsibilities, continuing care delivery, providing post-incident support and debriefing those involved.

Leadership

Organisational violence prevention, reduction strategies and associated policies must be endorsed by the board or senior responsible manager. Strategies and policies should include clearly defined objectives and performance criteria allowing senior management teams to record, monitor and review the effectiveness of violence prevention and reduction programmes; access to suitable data dashboards is crucial to ensuring adequate oversight.

An opportunity exists for senior leaders to drive and champion improvements that support the prevention and reduction of workplace violence, supporting staff effectively and compassionately.

Future considerations

The NHS continues to identify ways to tackle and reduce violence against staff. We believe this could be developed further through an NHS National Violence Reduction Strategy, a key element of which should include the collation of data concerning workplace violence locally, regionally and nationally.

The development of such databases will permit detailed analysis and rigorous evaluation of improvement measures implemented. The Social Partnership Forum[e] is ideally placed to be involved in the development and implementation of such a strategy.

[e] The Social Partnership Forum brings together NHS Employers, NHS trade unions, NHS England, and the Department of Health and Social Care, to contribute to the development and implementation of policy that impacts on the health workforce.

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