Violence against social care and support staff

Summary of research

November 2013

Violence against social care workers composite report: Summary of research

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Ministerial foreword

The Department of Health deplores any form of violence against social care staff. Violence against social care staff is clearly an area of concern for all those involved in care and support. Any act of violence against social care workers is wholly unacceptable. The most important concern is the safety of individual care workers but we must also be conscious of the impact on the sector as a whole. It poses a risk to the recruitment and retention of a quality workforce needed to face the challenges of the future.

Violence against staff can occur in any work environment, including residential and day care settings, however one of the main risk areas is where staff visit or provide services to people in their own homes.

We need to ensure employers and individuals manage the risk of violence effectively and that they respond appropriately when an incident occurs.

The Department asked Skills for Care to undertake new research into the extent of the problem of violence against staff in 2012. Three key issues were examined;

- the trends and current prevalence of violence against social care and support staff;
- guidance and monitoring procedures employers are using to record violence incidents; and
- what the sector can learn from the NHS in response to violence against staff.

I am pleased that the report of the findings of this commission 'Violence and the social care workforce' is now being published.

This is an important milestone in better understanding the issue of violence against care staff and in mitigating its harmful and distressing effects on the social care workforce and the sector as a whole.

The report and its findings will provide the basis for discussions with social care employers on the issue of violence towards staff and further work will build on this insight to develop an awareness of specific risk factors and successful approaches to managing the risk.

Norman Lamb MP
Minister of State for Care & Support

Acknowledgements

Executive summary

Introduction

Skills for Care (SfC) were asked to consider the following questions posed by the Workforce Division within the Department of Health (DH):

1. What are the trends and current prevalence of violence against social care and support staff?
2. What current guidance and monitoring procedures are employers using to respond to and record violence against social care and support staff?
3. What actions have been taken within the NHS in response to violence against staff and how can social care learn from their experiences?

Desk-based research, an evidence review, online survey (n=162), 40 depth interviews with employers and interviews with 5 key stakeholders in the NHS and the HSE have informed this report.

Prevalence and trends

It is clear that violence and abuse are key issues in social care but it is difficult to give an exact indication of prevalence or trends in the number of incidents experienced by staff. Figures range from 93% of staff experiencing verbal abuse through to 56% experiencing physical abuse. Suffice to say, the majority of staff involved in the research across the board had experienced some form of violence or abuse in their current position.

There is some evidence that staff working with people with learning disabilities and autism, with dementia, with mental health problems and with substance misuse issues are more likely to be at risk than other staff. However, this is based on limited data so should be treated with caution. In addition, there is concern that lone workers and personal assistants may be at more risk as they lack the back up of other staff.

Policy and guidance

There is a clear legislative framework outlining employers' responsibilities to protect staff from violence and abuse at work. In addition, the National Task Force for Violence against Social Care Staff outlined the requirement to maintain full and accurate data supported by guidance to promote good practice and reduce violence. While this was updated in 2010, there is still no national level policy direction to support employers in recording, monitoring and responding to violence against the social care workforce.

At a local level, three-quarters of social care employers who took part in the online

survey had policies to deal with violence and abuse. However, many were general workforce policies rather than social care specific policies and there was a clear gradient in terms of organisation size; with larger organisations more likely to have policies and procedures in place.

Reporting of incidents

Under-reporting of violence and abuse is widely recognised for a variety of reasons:

- Violence and abuse was viewed as part of the job and often linked to medical conditions e.g. dementia
- There is a lack of clarity around what constitutes violence or abuse
- Staff are unclear of the next steps following an incident
- Some staff may fear that admitting to a violent incident will reflect badly on their competencies
- Active avoidance of paperwork.

The research indicated employer understanding of the need to be aware of violence and abuse in order to reduce incidents by identifying patterns of behaviour and trigger factors. Many reported support for staff through training, procedures, and an open door policy. While this is encouraging, the way in which data is collected is inconsistent and while larger organisations may have electronic recording, smaller organisations were more likely to rely on accident books.

Support for tackling violence against social care and support staff

Evidence would indicate violence and abuse has a negative impact on staff morale, motivations, retention, absenteeism, perception of staff value and stress levels in the workplace. Employers offer a range of support to help both prevent violence and abuse in the first instance, and support for staff should an incident occur. As with other areas, responses vary across the sector and there is no consistent approach to how this is tackled. However, evidence from across the studies highlight the following as good practice:

- Supportive management following an incident
- Effective training for staff
- Clear and consistent guidance for staff
- Formal debrief of the circumstances surrounding the incident
- Review of risk assessment and risk management process as ongoing part of case management
- Preventive approach to managing violence and abuse
- Open organisational culture.

Responses to violence and abuse

Two main organisational responses were highlighted: risk assessment and learning from experiences. The majority of responses to the research indicated that following an incident, a risk assessment review took place and some reported a flagging system for high-risk individuals. In addition, many organisations reported some form of debrief: team meeting; action learning set; shared scenarios etc. to extract learning from an incident or in some cases, a near miss.

Learning and development

Learning and development is an important aspect of managing violence against social care and support staff and included training, use and understanding of guides and resources.

Our research indicated that for staff it was important to:
- Understand specific medical conditions and associated triggers to violence
- Develop de-escalation and physical breakaway techniques
- Have skills to manage a violence incident once it has happened.

Organisations were also using a range of national resources (e.g. Skills for Care: Domiciliary care lone worker safety guide) and felt these were useful and would feel happy recommending them to others. However, there was a request from employers involved in the research to consider the role of a national framework and approach to support and train staff in managing violence and abuse, recognising the need to tailor for some groups. Key benefits highlighted included: increased corporate responsibility; standardised approach to the issue; standard minimum level of training for staff; and added strength to the argument of tackling violence against the social care workforce.

Learning from the NHS

There are similarities to the NHS in terms of client group however, key differences include both the nature of the relationship; in social care this is more likely to be a longer-term relationship, and linked to this the language used (challenging behaviour tends to be used in social care). Nonetheless in terms of process, key elements of the NHS response include:
- National strategic body with responsibility for reducing violence against healthcare staff
- National level policy framework for action soon to be replaced with a requirement in the Standard Contract to adhere to NHS Protect standards in this area
- Strategic and local partnerships to support staff and patients

- Efforts to shift staff attitudes and organisational culture from 'part of the job' mentality
- A dedicated workforce through area security management specialists (ASMS) and local security management specialists (LSMS)
- Ongoing policy, guidance and training for staff driven from the centre and developed in partnership with local SMSs
- Clear and consistent guidance on the parameters of what constitutes violence and abuse, what to report, when and how
- A national reporting and monitoring structure which provides clear and accurate analysis of the data provided at a local level on risk groups, trigger points, trends and prevalence.

The NHS has seen a reduction in the number of violent incidents in recent years indicating the package of measures is having some impact.

Recommendations

Culture change

From the research conducted and learning from the NHS, it is important to consider the current culture in social care in this area. The research highlighted many reasons why staff were not reporting violence and abuse, including fear of losing their job, concerns about their performance, lack of understanding around what constitutes violence and abuse. Moving forward there is an opportunity to begin to shift this culture through small steps, for example, being clear from the centre what is meant by violence and abuse, and what and when to report incidents. By setting out parameters, it becomes easier for employers and staff alike to recognise and be more realistic about the scale and scope of the issue in their organisation.

National drivers

A much bigger consideration for culture change is the need for direction from the centre, supported by local areas to develop and deliver consistent and clear policy in this area. This would require considerably more thought and resources but if successful, could impact on the level of violence and abuse that social care and support staff are currently experiencing.

There was support from the research for a nationally driven agenda in this area both in terms of learning and development but also for recording and monitoring of information to develop understanding of the scale and scope of the problem, to help identify staff most at risk, to measure improvements and help monitor the impact of the austerity budgets on care services with regard to violence at work. However, this is not

without its challenges given the limited resources available, the variation in current recording and monitoring systems and the additional burden on employers. However, these challenges are not insurmountable as seen in the NHS where they are headed toward a single recording system and have developed standards for inclusion in the standard contract regarding security management.

Staff learning and development

It is clear from the work in social care and substantiated by the learning from the NHS that learning and development has a key role to play in reducing the incidence of violence and abuse against social care and support staff. A cornerstone of the NHS Protect approach is staff training to educate staff on both what constitutes violence and abuse (as discussed above) but also techniques to de-escalate situations and handle violence and abuse. While there is a range of training on offer, there is some desire for a minimum standard to be set for staff and organisations in order to help employers through the plethora of potential courses, but also to standardise staff approach and attitudes to violence and abuse.

Staff most at risk

While there is no clear picture, the emerging data would suggest that staff working with people with learning disabilities and autism, older people with dementia, and to some degree people with mental health or substance abuse issues are the ones most at risk. There is value in working with these groups to ascertain in more detail learning and development needs, potential policy support and facilitated learning between organisations etc. to begin to develop a co-ordinated approach to violence reduction.

Additionally, lone workers face additional risks which have been supported through existing guidance. However, more information on the situation for personal assistants is needed. While this current research included some input from PA agencies, this was relatively small scale and further research could provide useful insight into the extent, current responses and gaps in provision in order to support this group more effectively.

Finally, while there was limited acknowledgement of racial abuse as being an issue this could be in part because the numbers are limited. Any work going forward should be conscious of this aspect of abuse, as it could be an area of under-reporting or lack of recording (e.g. some areas did not collect information on ethnicity).

Sharing good practice

The research highlighted the need for more training but equally employers were keen to learn from each other and this could include health and social care organisations. There is potential for a more structured approach to utilisation of good practice, discussion of common issues and evaluation of training etc. between employers. This would be of particular use to smaller employers who don't have access to the same policies, procedures and resources as larger organisations.

Further research

While this research included personal assistants, the main emphasis was on organisational responses to violence and aggression. More work could build on the insights of this research to further understand the specific issues facing this group.

Further consideration of health and social care integration is required in light of recent policy developments, which could include integration of security management systems.

1. Introduction

1.1 Purpose of the report

Skills for Care (SfC) were asked to consider the following questions posed by the Workforce Division within the Department of Health (DH):

1. What are the trends and current prevalence of violence against social care and support staff?
2. What current guidance and monitoring procedures are employers using to respond to and record violence against social care and support staff?
3. What actions have been taken within the NHS in response to violence against staff and how can social care learn from their experiences?

In response Skills for Care agreed three main approaches to address these questions:

	Desk based research	Fieldwork with employers and staff	Discussion with stakeholders
Question 1: Trends and prevalence	●		
Question 2: Guidance and monitoring	●	●	●
Question 3: NHS actions and learning	●		●

IPC Brookes Oxford University were commissioned to conduct fieldwork across the three areas and this report draws on findings from the three reports[1]:

- Cairncross L & Kitson A (2012a) *Violence against the social care workforce: Evidence Review*. Skills for Care: Leeds.
- Cairncross L & Kitson A (2013b) *Response from online survey – violence against the social care workforce*. Skills for Care: Leeds.
- Cairncross L & Kitson A (2013c) *Analysis of interviews on violence against the social care workforce*: Skills for Care: Leeds.

In addition, Skills for Care completed desk-based research to establish: national and local policies and guidance; the NHS response to violence against healthcare staff through interviews with key stakeholders.

1.2 Definitions

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[1] Please visit www.skillsforcare.org.uk to access the full reports

For the purposes of clarity, this research has used the following definition of violence, which is taken from the Health, and Safety Executive cited in the NHS Direct's Violence in the Workplace policy (NHS Direct 2012) but social care has been substituted for health care.

> *"Any incident in which a person working in the [social] care sector is verbally abused, threatened or assaulted by a [person in receipt of services], member of the public or a member of staff arising out of the course of their work''*

2. Trends and prevalence of violence against the social care workforce

The evidence review found that any discussion of the prevalence of violence against social care and support staff requires a caveat. This is because a wide range of definitions and indicators of violence as well as categorisation of staff and work areas make the available data complex. Nonetheless, there is some evidence which is best summarised in the table below.

Table 1: Summary of prevalence data

Author & Year	Prevalence	Sample details
Brockman and McLean, 2000	37% physically attacked in current job	1,031 social services managers, field, residential & home care workers in England, Scotland & N Ireland
Emerson and Hatton, 2000	70% experienced a violent incident 64% insulted or shouted at 40% threatened with violence 38% physically attacked in past year	Social care workers in England (LD & MH). Sample size not stated
McGregor, Community Care, 2010	90% experienced abuse, assaults and threats One-third physically assaulted, 90% verbally abused while on duty 80% experienced more than one '*abusive incident*' in past year	114 social workers (Children and adult services)
Unison, 2011a	75% verbally attacked, 44% threatened at least once, 16% physically attacked 3% cyber-attacked (in current job)	Support workers and assistants in social work services. Sample size not stated
Harris and Leather, 2011	93% verbally abused at some point in their employment 71% threatened or intimidated 56% physically assaulted	363 social care staff in a UK Shire County Department
Cairncross and Kitson 2013b	55% of sample reported verbal abuse and 52% reported	67 responses from online survey

Author & Year	Prevalence	Sample details
	physical abuse against staff in last 12 months	

From Cairncross & Kitson (2013b) it was clear that verbal abuse was the most widespread form of abuse to have occurred (55%) and the most frequent. Physical abuse was also widely reported (52%) although the frequency of these incidents in the last 12 months was much lower. Around a quarter of respondents reported racial abuse (27%) and threats (27%) although again the frequency was low.

The online survey asked which of the incidents which have been recorded in the last 12 months represented the most serious threat towards staff. Physical assault was deemed the most serious: 59% of respondents ranked it as the number one threat; followed by sexual assault (18%) and verbal abuse (15%). Racist abuse was rated as being the most serious threat by 1% of respondents. Internet abuse, threats, harassment and assault against staff property were rated as the most serious threats to staff by less than 5% of respondents.

The qualitative work with employers (Cairncross & Kitson 2013c) was able to delve into more detail about experiences of violence and aggression. There was considerable variation in experiences around the scale of the problem with some indicating it wasn't an issue, others feeling it was a constant factor, and some reporting that while things were stable, the seriousness of the incidents were increasing. There was, however, an emerging pattern that staff working with people with learning disabilities, autism and older people with dementia were the most likely groups to experience violence and abuse[2]. Among those responsible for domiciliary care, violence and aggression was not perceived as a common problem although some concerns were raised about lone workers the need for more information around personal assistants was highlighted.

Interviewees from across service types and population groups mentioned a number of factors affecting the incidence of violence or abuse:
- Verbal abuse and aggression has increased from relatives and carers, possibly due to: a weakening of respect for care and support staff; tensions between what individuals using care and support services want and what families want for them; the impact of budget constraints and the greater likelihood that staff will have to refuse requests for some services.

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[2] Note, the sample focused on residential care homes, included learning disability services but did not tap into other specialist services, e.g. addiction services, mental health services etc.

- Increases due to changes in the profile of people using care and support services: more advanced levels of dementia, people with autism – '*more difficult to manage*'.
- Reductions in levels of violence and abuse as a result of staff training and other preventive work – particularly in relation to learning disability and complex needs, but also dementia – '*in our organisation, once people have had training and follow our ethos, incidents do reduce'*.

2.1 Risk factors

The evidence review would suggest that care workers are more at risk of violence than other occupational groups. Analysis of the 2010/2011 British Crime Survey found health and social welfare associate professionals have a relatively high risk of assault or threat at work compared with other types of work. Risk factors identified by the evidence included:

- Residential care working
- Lone working
- Working with people with a mental health problem
- Working with people with a substance or alcohol misuse issue
- Younger staff.

2.2 Summary

It is clear that violence and abuse are key issues in social care but it is difficult to give an exact indication of prevalence or trends in the number of incidents experienced by staff. Figures range from 93% of staff experiencing verbal abuse through to 56% experiencing physical abuse. Suffice to say, the majority of staff involved in the research across the board had experienced some form of violence or abuse in their current position.

There is some evidence that staff working with people with learning disabilities and autism, dementia, mental health problems and substance misuse issues are more likely to be at risk than other staff. However, this is based on limited data so should be treated with caution. In addition, there is concern that lone workers and personal assistants are at more risk as they lack the back up of other staff.

National level monitoring would be required to fully collect and understand the prevalence and trends associated with violence against the social care workforce in order to pinpoint triggers, risk factors and specific groups more likely to demonstrate violence to make interventions more targeted and effective.

3. Current guidance and policy

In terms of current guidance and policy, desk-research and the evidence review identified a legislative framework, as well as international and national guidance for employers in this area and local level responses to both. It should be noted that there appears to be considerable local variation in practice when it comes to tackling violence against the social care workforce.

3.1 Legislative framework (general)

In particular the following have a direct impact on an employers' responsibility to protect social care and support staff from violence and abuse at work:

- The Health and Safety at Work etc. Act 1974: employers have a legal duty under this Act to ensure as far as possible, the health, safety and welfare at work of their employees and others who may be affected by their undertaking.
- Safety Representatives and Safety Committees Regulations 1977 and the Health and Safety (Consultation with Employees) Regulations 1996: Employers must inform and consult with employees in good time on matters relating to their health and safety.
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995: Employers are required to notify their enforcing authority in the event of an accident at work resulting in death, major injury or incapacity for normal work for seven or more days. This includes any act of non-consensual physical violence against a person at work. This does not include verbal abuse.
- The Management of Health and Safety at Work Regulations 1999: Employers must have suitable arrangements in place to manage the risk from violence to employees and others. Arrangements include identifying the risks, implementing reasonable practicable control measures and monitoring their effectiveness.
- The Corporate Manslaughter and Corporate Homicide Act 2007 allowing prosecution of companies and organisations where serious mismanagement results in a gross breach of a duty of care.

Through the National Task Force for Violence Against Social Care Staff (2000) there was a requirement to maintain full and accurate data and guidance outlining the principles designed to promote good practice and strategies to reduce violence. This work was updated by Skills for Care[3] along with the DH, ADASS and Local Government Employers (2010). Subsequently, awareness was greater, training was delivered, and reporting of incidents and risk reduction strategies had improved. However, they concluded that there were still too many incidents of violence and practices for risk reduction were inconsistent across the country.

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[3] www.skillsforcare.org.uk for more detail.

3.2 Local responses

Cairncross & Kitson (2013b) found in their survey of 160 employers and staff that nearly three-quarters of respondents indicated that their organisation had a policy and/or procedure in place for dealing with an incident of violence or abuse carried out against them. However, a higher proportion (85%) responded to a follow-on question about whether the policies were specific to social care workers or the workforce in general. This indicates that between 15% and 27% of organisations did not have policies and procedures for staff to follow where an incident of violence or abuse was carried out against them.

In terms of organisational variation, Cairncross & Kitson found that domiciliary and community services were most likely to say their organisation had policies and procedures for staff to follow if there was an incident of abuse or violence carried out against them (over 80%), while care homes with and without nursing and extra care housing services were less likely to have policies and procedures (over 70%).

The survey also noted that 55% of respondents reported a general organisational policy for violence in the workforce and only 40% had social care specific policies. Figures from a recent Community Care survey reflect this variation in specific vs. general and found that a third of local authorities that responded to a freedom of information request had a specific social care policy.

Cairncross & Kitson (2013b) found a clear gradient in terms of organisation size – respondents from larger organisations were more likely to say they had policies and procedures in place: 63% among those with up to 10 employees compared with 78% of those with over 250 employees.

Both the desk research and online survey found that a 'typical' local policy covered:
- Legal and policy context
- Risk assessment
- Dealing with violence
- Bullying and harassment
- Violence and aggression at work
- Lone working
- Incident reporting
- Physical intervention policy
- Health and safety issues.

3.3   Summary

While there is a range of policy and guidance documents available locally and nationally, there is no consistent approach to managing violence against the social care workforce. This fragmentation may reflect local issues and concerns but a more co-ordinated approach has the potential to draw together learning and strengthen the response to violence and abuse.

4. Reporting of incidents

From the evidence review it is clear that under-reporting of violence against social care and support staff is widely recognised. This appears to reflect under-reporting by both staff and employers. This results in a two-fold problem; a lack of clarity regarding the scale and scope of the problem and a lack of understanding about the detail of the event, for example, what triggered the incident.

Through both the online survey and qualitative interviews with employers, Cairncross & Kitson (2013b, 2013c) investigated attitudes to reporting. Encouragingly they found that in general, reluctance to report abuse against staff was not seen as an issue. However, there was a concern that staff were under-reporting for other reasons:

- Part of the job: there is a view from some staff that violent and aggressive incidents are part of the role and therefore become complacent about their occurrence
- Linked to medical conditions: linked to bullet one, in some instances staff 'excuse' violent and aggressive incidents because of the nature of the medical condition of the individual using services, for example, an elderly person with dementia
- Unclear of what constitutes violence: some staff are not clear what constitutes violence and abuse beyond a physical assault
- Unclear of next steps: staff can be unsure of the next steps once a violent incident has happened
- Fear of impact on their job: Given the current employment status of a number of care workers, e.g. zero hour contract, there is a view that reporting an incident would 'rock the boat' and potentially impact on their job
- Reflection on staff competence: At a different level, some staff feel that they are unable to report an incident as it might reflect on them as a carer because they somehow let it happen
- Avoidance of paperwork: finally, some felt staff were not reporting incidents because of the associated paperwork and follow up with potentially little action or resolution.

The qualitative interviews indicated broad support for staff to report incidents of violence highlighted through induction training, organisational policies and procedures and an ongoing supportive environment. Many indicated the importance of reporting for the organisation as a whole in order to identify patterns of behaviour and trigger factors.

4.1 National monitoring

Beyond their legal duties to regulators (CQC and HSE), there are no national arrangements in place within social care to record and monitor incidents of violence and

abuse. In 2011, councils rejected a proposal from unions for a national register of violent incidents involving social care and support staff in favour of local reporting systems. The Local Government Employers cited different reporting mechanisms across the different councils as a major obstacle to national level reporting. In addition, they argued that local authorities responding to local risks based on good guidance would be more effective than a national register. This view is not shared by organisations such as the British Association of Social Workers or UNISON. UNISON have developed a 10 point plan to progress this issue which includes additional funding to match NHS programmes of work, risk assessment and prevention strategies, standardised reporting and recording systems, improved local response, national system of monitoring incidents, easy access to post-incident support and counselling, improvements to lone working, closer relationships between the police/CPS and employers and finally, better protocols for mental health between employers, police and ambulance services.

The online survey (Cairncross & Kitson 2013b) indicated there was wide support for the introduction of a national monitoring system with 81% of respondents indicating this as a useful step forward. There was cognisance that monitoring at a national level would make it possible to understand more fully which groups are most likely to be violent or abuse staff, and which staff are most vulnerable to violence and abuse. In particular, employers in the qualitative study felt it would help to:

- assess the scale of the problem
- raise awareness
- encourage reporting by staff
- monitor the impact of the austerity budgets on care services in this area.

However, there were some concerns expressed through the survey and interviews about how such a system might operate in practice and whether the information would be used effectively. In addition, how any new approach would be resourced and embedded into practice, for example, the need for a shared understanding of what constitutes a violent incident worth recording.

4.2   Local monitoring

Community Care's Freedom of Information request asked councils in England for information on monitoring and recording systems for violence against social care and support staff. 101 councils (from a possible 152) responded to the request for information and of these, 89 reported they had a system in place for recording violence incidents against both children's and adult social care and support staff. However, it was not clear from our desk-based research what systems were in place.

Our research would indicate that respondents are engaged in monitoring and recording incidents of violence and aggression against the social care workforce. For example, in the survey more than four-fifths (83%) indicated that their organisation does monitor incidents of violence and aggression, with 89% taking further steps to review and evaluate the information collected. Of these respondents, 94% stated that policies and procedures were reviewed as a consequence of monitoring. Note, only around half of respondents completed this question, and although we can't assume, one reason for non-response might be the lack of monitoring and review.

The level of detail collected following an incident varied by respondent; however, most respondents in the survey indicated they collected the following:

- Type of assault (95% always collected this information)
- Where the assault occurred (95% always collected this information)
- Who the assailant was (91% always collected this information)
- Service user group (87% always collected this information)
- Service area (87% always collected this information)
- Lone worker (84% always collected this information)
- Response by staff member (83% always collected this information)
- Action by staff member (83% always collected this information)
- Incident report completed (82% always collected this information)
- Action by organisation (79% always collected this information).

From the qualitative work with employers we note the situation is more complex. Smaller organisations are more likely to record incidents through daily care charts or accident books, whereas larger organisations were likely to use spreadsheets or have electronic methods in place to record incidents. This often included a flagging system for high-risk situations or individuals, and reporting to Health and Safety departments. This more sophisticated approach to recording lends itself to more understanding of the situation and preventive approaches worth considering to reduce violent incidents in future.

The online survey did discover more about local recording processes. The table below indicates the types of incidents recorded in organisations.

Table 2: Nature and frequency of incidents recorded in organisations

	Always (%)	Sometimes (%)	Never (%)
Physical assault	67	25	8
Sexual assault	63	11	26
Threats	56	31	13
Assault against staff property	56	19	25
Racist abuse	53	33	14
Harassment	52	29	19
Verbal abuse	50	44	6
Internet abuse	37	24	39

Source: Cairncross & Kitson 2013b

The qualitative interviews reflected this picture of individual organisations' willingness to capture data in this area, but highlighted the variation in reporting mechanisms and classification of violence and abuse.

4.3   Summary

From the research it is clear that organisations are recording and monitoring violence and abuse to varying degrees. While there is currently no national monitoring system, there is support for this from the field although difficulties associated with such a step are noted. Nonetheless, employers are clear as to the benefits of a more co-ordinated approach to data collection in reducing violence and abuse against their staff.

5. Support for tackling violence against social care and support staff

5.1 Impact of violence on staff

It is important to tackle violence against the workforce as the impact of violence can be negative and long-lasting (Cairncross & Kitson 2012a). The evidence review indicated that feelings of fear and stress are widely reported in this context but being optimistic or over cautious to risk may be damaging to practice and personal safety.

Further, qualitative work with employers (Cairncross & Kitson 2013c) indicated violence and abuse had an impact on:

- Staff morale
- Individual motivation and feelings – ranging from staff burn out to extreme cases where staff can feel traumatised following an incident
- How staff perceive their own value to people using care and support services
- Staff retention
- Staff absenteeism.

5.2 Support for staff

The evidence review would indicate there is very limited recent research on what support exists for tackling violence against social care and support staff beyond the Community Care surveys. Unison (2011) found that many support workers and assistants reported that their employer treated threats as 'part of the job' and an element of blame was perceived attached to the worker if they were attacked.

In part this was supported through the qualitative work with employers. Staff in some settings had accepted violence as part of the job *"staff have accepted they are here to be abused"* was one comment from a learning disability residential care provider. Mixed in with this is the notion that violence is associated with particular medical conditions therefore it was accepted because there was a reason for the behaviour *"staff understand it's because of the clients' condition"*.

Cairncross & Kitson (2013b, 2013c) found that some form of support to staff was universal. Staff are most frequently supported through supervision and management debrief, followed by counselling and training. In practice, the approaches varied, but some form of reflection following an incident was highlighted as important in order to identify trigger factors for future information.

> '*We take them through a process of reflection to see if they can identify any relevant triggers to avoid it [the violence or abuse] happening again.*'
>
> Older people's residential care provider

Larger organisations involved in the qualitative work spoke of independent counsellors for staff who required it; Employee Assistance Programmes and occupation health support. If an incident resulted in sick leave, some organisations mentioned a phased return to work, or ensuring the staff member was not involved in the care of the individual involved through changing site or shift patterns. Smaller organisations tended to have more limited support available, e.g. peer support or management support.

Preventive work and the need for training was also emphasised through the research both to understand the risks involved but also to de-escalate incidents or handle the situation if an incident occurs.

> '*For someone with dementia, they haven't the ability to react by walking away. If staff understand this, then they can cope with the situation much better.*'
>
> Older people's residential care provider

The figure below is taken from the online survey and illustrates the range and extent of support and responses available to staff.

Figure 1: How are staff supported following an assault or abuse against them?
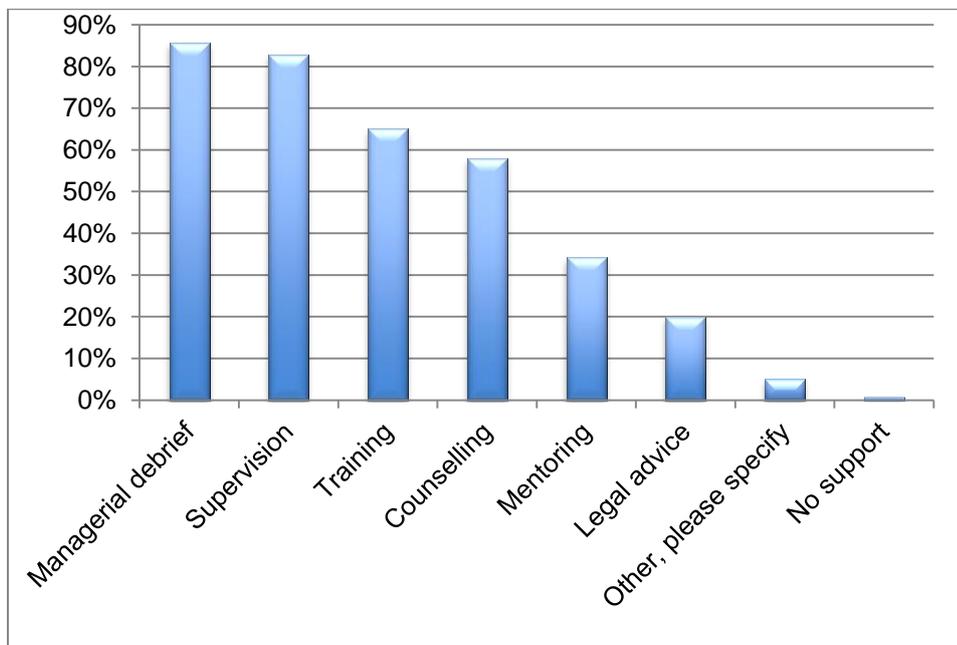
Source: Cairncross & Kitson 2013b (n=140)

From the collective research, the following characteristics of good practice can be extracted. In advance of an incident:

- Effective training for staff
- Clear and consistent guidance for staff
- Review of risk assessment and risk management process as ongoing part of case management
- Preventive approach to managing violence and abuse
- Open organisational culture.

Following an incident:

- Supportive management following an incident
- Formal debrief of the circumstances surrounding the incident.

5.3 Summary

Evidence would indicate violence and abuse has a negative impact on staff morale, motivations, retention and absenteeism, perception of staff value and stress levels in the workplace. Employers offer a range of support to help both prevent violence and abuse in the first instance, and support for staff should an incident occur. As with other areas, responses vary across the sector and there is no consistent approach to how this is tackled.

6. Responses to incidents

Responses to violence varied by organisation but often involved a risk assessment review and learning from experiences.

6.1 Risk assessment

Of those responding to a question about whether their organisation had a risk assessment in place (87 responses), 82% had a risk assessment process in place for specific population groups, and nearly all (97%) had a risk assessment process in place for individual cases. A similar high percentage (97%) also stated that risk assessments were reviewed following violent incidents.

The qualitative research (Cairncross & Kitson 2013c) indicated that risk management was a priority for the majority of organisations and individual risk assessments incorporated into care plans was a common occurrence. Many organisations operated a 'flagging' system for high-risk individuals and were taking preventative steps to reduce violence:

> *"They* [staff] *work in a person-centred way and therefore ensure people are supported by the appropriate people, for example, if the service user would prefer a male carer, they try to do that*".
>
> <div align="right">Autism and complex learning disability care provider</div>

6.2 Learning from experience

Many organisations have some form of structured of approach to learning from incidents including: staff meetings, team meetings, action learning sets, shared scenarios, incident analysis and reports to Health and Safety committees.

Staff and team meetings were the most widely mentioned methods in the qualitative work and these along with peer support were identified as particularly important for lone workers.
Larger organisations tended to have a variety of methods for sharing learning from incidents of violence or abuse against staff:

> '*Incidents are dissected, analysed and understood. The learning is disseminated through committees. Staff group meetings – managers cascade the learning through their teams.*'
>
> <div align="right">Older peoples' service provider</div>

Some organisations linked these approaches to training and development, and some mentioned having a '*lessons learnt*' approach within the organisation which encourages openness. In smaller organisations, it appears that learning is frequently more informal.

6.3   Summary

Two main organisational responses were highlighted: risk assessment and learning from experiences. The majority of responses to the research indicated that following an incident, a review of risk assessment procedures took place and some reported a flagging system for high-risk individuals. In addition, many organisations reported some form of debrief: team meeting; action learning set; shared scenarios etc. to extract learning from an incident; or in some cases, a near miss.

7. Learning and development

Learning and development is an important aspect of managing violence against social care and support staff and includes training, and the use and understanding of guides and resources.

7.1   Training

The online survey and qualitative research indicated that for staff it was important to:

- Understand specific medical conditions and associated triggers to violence
- Develop de-escalation and physical breakaway techniques
- Have ability to manage a violence incident once it has happened.

A range of in house and external training sought to cover these bases through course like Understanding Dementia, Conflict Resolution and Physical Intervention Techniques. Most offered training in risk assessment and often training was specific to their population group and particular issues faced. There was a preference for face-to-face training, rather than eLearning as this was perceived to be more appropriate and effective. The extent to which training was deemed effective was largely based on anecdotal evidence rather than organisational evaluation.

Interestingly, lack of training was seen as a real barrier to effective management of violence and abuse. For example, lack of understanding of a medical condition might make situations worse.

7.2   Guides and resources

From the online survey respondents indicated that national resources listed in the survey were used by between a half and three-quarters of organisations. These included:

- National Occupation Standards for Health and Social Care
- Skills for Care: Domiciliary Care Lone Worker Safety Guide
- Skills for Care: Work Smart Work Safe
- National Taskforce: Self Audit Tool
- Unison: Violence at Work.

Where used, resources were felt to be useful and respondents indicated they would recommend to others to varying degrees. However, there appears to be scope to raise awareness about some of the most useful resources. A wide and diverse range of resources are used locally, and there was no strong steer as to what additional learning

and development resources are needed, apart from the importance of training and risk assessment.

However, while respondents were using national level resources, there was a request from employers involved in the qualitative work to consider the role of a national framework in this area to support and train staff in managing violence and abuse, recognising that there would be some requirement to tailor work to particular target groups. Benefits of a national framework or good practice guide included:

- Added strength to the argument for tackling violence against social care and support staff
- Increased corporate responsibility
- Raised profile for personal safety among staff
- Standardised approach to the issue
- Increased feeling of value and protection among staff
- Standardised minimum level of training
- Help fill a regulatory gap for personal employees and those employed by direct payments.

7.3   Gaps in learning and development

The research indicated that a wide and diverse range for resources are used locally, and many expressed the need for further training options, in particular accredited courses. The call for accreditation stems from the plethora of training courses available but little information on appropriateness or effectiveness. There was a view that accreditation would help with the sifting process and guide employers to more useful spend on training. This is an important consideration in the current financial climate which is impacting on the level of training given.

One suggestion for 'plugging' the gap would be to share and disseminate good practice where possible. Employers involved in the qualitative research were keen to learn from others, especially in smaller organisations and felt there was value in having case studies, scenarios and information about effective training. This tied in with a view that the evidence base should be stronger and reflect outcomes.

7.4   Summary

The role of learning and development was highlighted in the research and employers are keen to use national level resources and move onto thinking about a national framework to help support action in this area. In addition, respondents were keen to raise the idea of accredited training and dissemination of effective and good practice to help maximise the impact of spend in this area. This would be tailored to different groups and involve learning from each other.

8. NHS response to violence against the health care workforce[4]

Motivations to address the level of violence and aggression in the workplace are important for the NHS for a number of reasons. Staff can be at risk as many hospitals and healthcare premises are designed to be accessible to the public, settings can often be a place where emotions run high (e.g. issues around waiting times), and other influences like drugs and alcohol might be in play as well. The impact of violence and aggression is a key factor for action as it can result in financial and human costs linked to staff taking time off work as a result of physical or psychological injury or stress. Working in this sort of environment can also influence staff morale, stress and absenteeism[5].

As health and social care support staff share many of the same risks, both working with vulnerable individuals in need of care and support and patients it is possible to learn from the experiences of the NHS. The response to violence and aggression has differed vastly between the two sectors. In part this might be due to the extent of contact staff have with violent and abusive individuals, for example, an A+E nurse will have limited contact with a patient while treatment is given but a domiciliary care worker providing personal care for someone with dementia will have a much longer term relationship with that individual. One manifestation of this can be seen in the language used. In social care, people tend to talk about 'challenging behaviour' rather than violence and abuse which has a different motivation and intent, and potentially a different response. Nonetheless, it is worth looking at what we can learn from the NHS and translating the learning into a social care context.

8.1 Strategic response to violence and aggression against NHS staff

In 2003, a conscious decision was made to address violence and aggression in NHS organisations and the then Secretary of State set out a number of areas for change in *A Professional Approach to Managing Security in the NHS* (Department of Health 2003). The strategy outlined the leadership role of the NHS Counter Fraud and Security Management Service (NHS Protect since April 2011) in protecting NHS staff and patients and their property. The strategy set out the remit to improve standards and professionalism within security management services that are delivered and although line operational responsibility will remain with individual health bodies, the Security Management Specialists (SMS) has responsibility for determining the legal and policy framework, operational guidance and minimum standards necessary to ensure that the objective of providing a secure environment for the NHS is achieved. The SMS also

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[4] This section is based on interviews with NHS Protect operational and policy staff, a LSMS, HSE lead with input from CQC.
[5] *A Professional Approach to Managing Security in the NHS* Department of Health 2003

provides central and regional support to local security management specialists (LSMS) to make sure standards are met. There are a number of elements to the strategy including:

- **LSMS**: Introduction of dedicated local professionals known as "Local Security Management Specialists" within each NHS Trust to lead on day-to-day work to tackle violence against NHS staff supported by high quality training, a professional and ethical framework, continuous CPD
- **Monitoring and recording**: The development of a consistent and national level incident reporting system for recording physical assault and a locally managed consistent reporting system for non-physical assault which can track cases from report to conclusion
- **Legal support**: The launch of a Legal Protection Unit to work with health bodies, the police and the CPS to increase the rate of prosecutions and provide advice on a range of sanctions against individuals who are violent toward staff and professionals working or providing services to the NHS.

In 2012 NHS Protect published *Tackling crime against the NHS: A strategic approach* (NHS Protect 2012)*,* which reinforces commitment to respond to a range of crime in the NHS including violence through work with new bodies emerging as a result of the new arrangements for commissioning health services, and continue to provide strategic and tactical guidance to health bodies. Specifically the five aims of the strategy are to provide national leadership, work in partnership with key stakeholders, establish a safe and secure environment, to lead investigations into financial irregularities and losses and to quality assure the delivery of anti-crime work with stakeholders.

8.2   Operational response to violence and aggression against NHS staff

The initial strategic response set out the key steps to help develop a framework for reducing violence and aggression against NHS staff. This framework allowed NHS Counter Fraud and Security Management Service to move forward and subsequently NHS Protect to ensure progression in this area.

In terms of management, the security management service within NHS Protect is supported by Area Security Management Specialists (employed by NHS Protect) and approximately 450 Local Security Management Specialists (locally employed by NHS Trusts and Foundation Trust hospitals).

This operational structure for the security management element of NHS Protects' work is supported by the usual policy, IT, HR, finance, marketing and communications etc. teams who support the whole organisation.

8.3 Policy action

Following the strategy in 2003, a number of changes have been made in the NHS, for example the introduction of NHS Foundation Trust Hospitals and NHS Protect have had to react to the changing environment to ensure ongoing adherence to the original ethos of the 2003 strategy. This has been achieved by introducing a full set of NHS Protect standards, including security management standards, into the new NHS standard contract for commissioning healthcare services. In effect the remit of the strategy now reaches beyond NHS Trusts, as all those commissioned or contracted by the NHS will have to adhere to the standard set out or risk breach of contract.

Learning for others: by working within current policy and reflecting changes at a national and local level, security management issues are now integrated into standard practice; a powerful position to be in. Others should consider how security management issues fit into current policy and potential for inclusion within future policy plans as having a central drive moves the agenda forward.

8.4 Strategic partnerships

NHS Protect works with other regulators to reflect on their requirements and the overlap in organisational footprints. For example, the HSE, CQC, NHS Litigation, to name but a few agencies, have an overlap in function. By entering into information sharing agreements, concordats, memorandums of understanding (MoU) etc., NHS Protect has managed to navigate a potentially difficult field. Now that security management is in the NHS standard contract for commissioning healthcare services, it is much easier to negotiate, nonetheless NHS Protect opt to take a customer focus approached to supporting regulators.

Learning for others: taking a customer focused approach and supporting regulators and organisations meet standards set has gone some way to reducing defensiveness and breaking down organisational barriers and concerns. Others should consider working in partnership with appropriate agencies recognising the long-term input and commitment that is required to achieve successful partnership working.

8.5 Local partnerships

In addition to strategic partnerships, local level partnerships are important when it comes to dealing issues on the ground, for example, responding to a violent or aggressive incident. So depending on the severity of the incident, LSMS's will work with the police, HSE etc. to ensure a full and appropriate response is undertaken. In order to facilitate better working relationships, Area SMS's and LSMS's work locally to foster partnerships and understanding. For example, Area SMS's are working with senior

police officers locally and crown prosecutors to put together a tripartite joint memorandum of understanding around the issue of capacity and information sharing under them mental health act. This will be used with police services locally.

Learning for others: it is worth taking some time to establish local partners and areas of common interest to foster better working relationships, break down professional barriers and deal more effectively with individual incidents of violence.

8.6 Culture change

NHS Protect and LSMS's recognise the importance of changing culture as part of the move toward a safer and protected workplace. Many staff felt that violence and abuse was 'part of the job' and often excused incidents as part of a medical condition or response to drugs etc. For example, mental health providers were initially the lowest reporters of violent incidents, and are now the highest as a result of the change in attitude. While violence can be explained in some instances, staff needed training to understand what constituted violence and abuse, how to report, when to report and what will happen as a result of reporting. NHS Protect published "Not part of the job" which sets out these parameters for staff and this was used on the ground by LSMS's and area SMS's to influence staff attitudes and culture. In addition, LSMS's will be working in local environments to change attitudes to acceptance of violence against staff and one mantra that was mentioned is 'nothing reported, didn't happen, nothing will change' so responsibility for making the change is placed with staff themselves.

Learning for others: Zero Tolerance is not the right message to promote among staff to change and influence culture as this is not realistic or achievable given the working environment where there is always the risk of violence. It is more realistic to focus on improving the culture to be more aware of violence, and understand what constitutes an appropriate response to a 'trigger' situation.

8.7 Training for staff

Culture will change through work on the ground, support from management and through learning and development. NHS Protect have an in house training department supported by a raft of tools for NHS organisations to use which are 'pushed out' through ASMS and LSMS. One main strand of training is preventative training and de-escalation methods, for example conflict resolution. In addition, local hospitals will use NHS Protect tools and materials but adapt for their own purposes and deliver the training themselves.

Learning for others: The right training will help influence culture and help staff response to violence and management of incidents. Others should think about central training

developments supported and potentially delivered by local SMS in order to maximize staff understanding and consistency to reporting violent and abusive incidents.

8.8   Reporting and monitoring

In order to provide a national picture, NHS Protect require organisations to report incidents, from which they can collate and produce annual reports, highlighting trigger points, issues in specific areas etc. However, at a practical level, the biggest challenge that NHS Protect faced was the different reporting systems in operation across health organisations. While ideally a centralised reporting system would be the best option, it was not possible to discount existing procedures, but rather work with organisations to glean information in different ways, initially with a view to moving to a more streamline system. Originally, organisations faxed their statistics to NHS Protect who inputted them into a central system but over time, there is now a bespoke IT solution (SIRS) interface with 4 risk-based systems that organisations in the NHS currently use. Eventually all of the NHS workforce will record incidents using SIRS but the national rollout will take time.

Learning for others: you need to work with the reporting reality and devise solutions rather than get 'stuck' thinking about the perfect IT solution. While it is good to have an end goal with regard to centralisation of reporting, working through staff on the ground will help collect initial data and having systems in place will allow the NHS to begin to fully understand the nature and extent of the problem. This initial information is essential to ensure a strong and appropriate strategic and policy response.

8.9   Response to violence

While responses may vary the important thing is to have a response. Staff will give up on reporting quickly if nothing is done as a direct result of their input. Depending on the severity of the incident, the NHS can respond in a number of ways from review of the situation and risk management through to full prosecution.

Learning for others: for a reporting and monitoring system to work, there must be some response to the report otherwise staff will lose trust in the system.

8.10   Ongoing policy developments

Within NHS Protect, an internal policy team works to continually improve policy and guidance in this area. While responding to the outcome of a violent incident, a good deal of focus is given to understanding violence and abuse, triggers, environmental factors, medical conditions, best responses and preventive actions. The team develop policy and guidance in a consultative way, drawing on the views and experiences of the LSMS and ASMS. Policies are broad and provide a framework for local organisations to

use, reflecting local practice and context.

Learning for others: developing flexible policy and guidance, with not for practitioners, will improve uptake and ownership in the long run. Information is crucial to policy development and guidance in order to best direct resources.

8.11 Operational staff

The structure of NHS Protect and connection with the field is outlined above, but while local staff are employed by NHS Trusts etc., each member of staff is required to undertake a 4 week training course which is fully accredited by Portsmouth University in order to have a consistent approach to security management across the workforce. This allows staff to have professional back up if necessary, and ensures consistent and high quality training across the board. LSMS's are required to attend 4 quarterly meetings facilitated by ASMS's which often will be used to consult on tools, policy and guidance that will be useful to frontline SM practitioners.

In the field, one example of working indicated that the security management staff were part of the medical and clinical team. For example, attendance at review meetings, team meetings etc. meaning SMS staff are included in the team and are not viewed as 'outsiders'. Integration is key to building trust among the staff and taking security issues more seriously.

Learning for others: while employment might vary locally, security management staff have the same basic approach and understanding to the issues facing healthcare staff via initial training which brings consistency and a level playing field. One approach that seems to have added value is integration of LSMS's into department teams.

8.12 Summary

Annual figures showing the number of physical assaults in each trust are published on the NHS Protect website - in 2008-09 there were 54,700 reported physical assaults against NHS staff in England, a reduction of 1,200 compared to 2007-08. It is not possible to attribute this fall in incidents to any one part of the work that is ongoing but as a package, the strategic and operational approach to security management seems to be delivering results for the NHS. The key points to consider follow:

- There is a need for national direction as well as staff taking the work forward on the ground to bring some 'weight' to the work and consistency of approach
- Partnership working, both strategic and operational, is key to reducing violence against the workforce
- There are a range of professions, environments, individuals using care and support services involved and it is important to have a direction but be flexible

and support individual areas to make policy and guidance work for them

- Culture change is crucial to moving forward in this area but a realistic approach to risk management and minimisation is needed, rather than idealistic goals to eliminate violence altogether
- Clear parameters for working and training will support staff in reporting violence and abuse
- It is important to collect data in order to focus resources on staff at most risk
- Operational staff have a key role to play in reducing violence in the workplace both to adapt and cascade national policy and guidance but also feed information back to the centre.

9. Recommendations

9.1　Culture change

From the research conducted and learning from the NHS, it is important to consider the current culture in social care in this area. The research highlighted many reasons why staff were not reporting violence and abuse, including fear of losing their job, concerns about their performance and lack of understanding around what constitutes violence and abuse. Moving forward there is an opportunity to begin to shift this culture through small steps, for example, being clear from the centre what is meant by violence and abuse and what and when to report incidents. By setting out parameters, it becomes easier for employers and staff alike to recognise and be more realistic about the scale and scope of the issue in their organisation.

9.2　National drivers

A much bigger consideration for culture change is the need for direction from the centre supported by local areas to develop and deliver consistent and clear policy in this area. This would require considerably more thought and resources but if successful, could impact on the level of violence and abuse that social care and support staff are currently experiencing.

There was support from the research for a nationally driven agenda in this area both in terms of learning and development but also for recording and monitoring of information to develop understanding of the scale and scope of the problem, to help identify staff most at risk, and to measure improvements. However, this is not without its challenges given the limited resources available, the variation in current recording and monitoring systems, and the additional burden on employers. However, these challenges are not insurmountable as seen in the NHS where they are headed toward a single recording system and have developed standards for inclusion in the standard contract regarding security management.

9.3　Staff learning and development

It is clear from the work in social care and substantiated by the learning from the NHS that learning and development has a key role to play in reducing the incidence of violence and abuse against social care and support staff. A cornerstone of the NHS Protect approach is staff training to educate staff on both what constitutes violence and abuse (as discussed above) but also techniques to de-escalate situations and handle violence and abuse. While there is a range of training on offer, there is some desire for a minimum standard to be set for staff and organisations in order to help employers through the plethora of potential courses, but also to standardise staff approach and attitudes to violence and abuse.

9.4   Staff most at risk

While there is no clear picture, the emerging data would suggest that staff working with people with learning disabilities and autism, older people with dementia and to some degree people with mental health or substance abuse issues, are the highest risk groups. There is value in working with these groups to ascertain in more detail learning and development needs, potential policy support, facilitated learning between organisations etc. to begin to develop a co-ordinated approach to violence reduction.

Additionally, personal assistants and people employed through direct payments are also at risk. This research had some input from PA agencies however, there is more work to be done in order to fully understand the risks they face, current responses and gaps in provision in order to support this group more effectively.

Finally, while there was limited acknowledgement of racial abuse as being an issue, this could be in part because the numbers are limited. Any work going forward should be conscious of this aspect of abuse, as it could be an area of under-reporting or lack of recording (e.g. some areas did not collect information on ethnicity).

9.5   Sharing good practice

The research highlighted the need for more training but equally employers were keen to learn from each other, and this could include both health and social care organisations. There is potential for a more structured approach to utilisation of good practice, discussion of common issues, evaluation of training etc. between employers. This would be of particular use to smaller employers who don't have access to the same policies, procedures and resources as larger organisations.

9.6   Further research

While this research included personal assistants, the main emphasis was on organisational responses to violence and aggression. More work could build on the insights of this research to further understand the specific issues facing this group.

Further consideration of health and social care integration is required in light of recent policy developments, which could include integration of security management systems.

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