House of Commons

Committee of Public Accounts

A safer place to work: Protecting NHS hospital and ambulance staff from violence and aggression

Thirty-ninth Report of Session 2002–03

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Report, together with formal minutes, oral and written evidence

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The Committee of Public Accounts

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The current staff of the Committee is Nick Wright (Clerk), Christine Randall (Committee Assistant), Leslie Young (Committee Assistant), and Ronnie Jefferson (Secretary).

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Summary

Reported incidents of violence and aggression against NHS staff are high and rising, with over 95,000 reported incidents in 2001–02. Nurses and care workers are at a higher risk of violence and aggression than most other workers (**Figure 1**). The impact on staff is immediate, in terms of injury and distress, and longer term with increases in stress, sickness absence, lower morale and productivity, and problems in retention and recruitment.

Figure 1: Occupations with a high risk of violent assaults while working (average risk is 1.2%)

Security and protective services	11.4%
Nurses	5.0%
Care Workers	2.8%
Public Transport	2.8%
Catering/hotel/restaurants	2.6%
Education and welfare	2.6%
Teachers	1.8%
Retail Sales	1.8%
Other health practitioners (including doctors)	1.4%

Source: Data from the British Crime Survey 2000[1]

In 1997 our predecessor Committee highlighted their concerns about the burden of accidents on the NHS, including violence and aggression, and the lack of information on the extent and costs.[2] The Department of Health (Department) took a number of actions in response to this report and in 1999 launched the NHS *zero tolerance zone campaign* which seeks to raise awareness of the need to report, and of the actions that staff and the public could expect Trusts and the Department to take.[3]

On the basis of a Report by the Comptroller and Auditor General,[4] we took evidence from the Department on the effectiveness of their strategies for dealing with violence and aggression and NHS Trust's arrangements for preventing or reducing incidents and supporting staff who experience violence and aggression. We subsequently took evidence on the management of wider issues of health and safety risks to staff, including issues such as stress and occupational health, and will be reporting separately on those issues.

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1   *Violence at work: New Findings of the British Crime Survey 2000,* Home Office and Health and Safety Executive, July 2001

2   2nd Report from the Committee of Public Accounts, *Health and Safety in NHS Acute Hospital Trusts in England* (HC 350, Session 1997–98)

3   Treasury Minute to 2nd Report from the Committee of Public Accounts, *Health and Safety in NHS Acute Hospital Trusts in England* (HC 350, Session 1997–98); HSE 1999/226, *Campaign to stop violence against staff working in the NHS: NHS zero tolerance zone*

4   C&AG's Report, *A Safer Place to Work: Protecting NHS Hospital and Ambulance Staff from Violence and Aggression* (HC 527, Session 2002–03)

We draw the following main conclusions from our examination.

- While there has been progress in encouraging reporting, there remains a significant level of under-reporting; many NHS Trusts are not using the standard definition promulgated by the Department; and the information collected by the Department does not differentiate between the types and severity of incidents. These factors limit the Department's understanding of the problem, and make it difficult to say how far the increase reflects an actual increase in incidents or to measure how well trusts individually and overall are performing. The next phase of the Department's zero tolerance zone campaign should set out the reporting requirements which Trusts should apply.

- Trusts have developed a range of measures to deter patients and visitors from becoming violent or aggressive, but there are no evaluations of the effectiveness of these deterrents and dissemination of information on effective measures is limited. Trusts are also carrying out risk assessments but the coverage varies, there are deficiencies in the skills of staff undertaking the assessments, and there is a lack of evidence as to the effectiveness of measure taken to counter risks. The Department should review the measures applied by Trusts, identify those which have been effective, and publicise these measures through their zero tolerance website and advisory material.

- The Department has been active in promoting partnership working with the police and Crown Prosecution service. While many Trusts have developed good relationships with these bodies, there is scope for further improvements, in response times and in pressing charges. The new Counter Fraud and Security Management Service is planning to develop a concordat with the Association of Chief Police Officers. NHS Trusts also need to take a consistent approach in reviewing all serious incidents, in the provision of support to staff and in feedback to staff on outcomes.

1 Measuring the extent and cost of violence and aggression

1. All employers have a statutory duty to protect their staff from work-related violence and aggression, under national and European health and safety legislation and the common law duty of care. In 1997–98 our predecessor Committee's Report on *Health and Safety in NHS Acute Hospital Trusts in England* highlighted the need to improve the recording of health and safety incidents in the NHS, including incidents of violence and abuse.[5] In response the Department of Health (Department) issued guidance to NHS Trusts to put in place policies and procedures to record, monitor and assess the causes and costs of accidents, sickness absence, ill health retirements and occupational ill health for all health and safety risks. They noted that the risk of violence and aggression should be managed like any other health and safety risk, and that Trusts should ensure that incidents were always reported.[6]

2. Our predecessor Committee's report highlighted evidence submitted by UNISON which had found that less than two thirds of staff were encouraged to report incidents, between 15 and 20% were discouraged from doing so, and a third of staff were unaware of the reporting procedures. The Committee looked to NHS acute Trusts to take a stronger lead in encouraging staff to report all accidents promptly.[7]

3. Two initiatives, launched in 1999, have been key to tackling the growing concerns about the level of violence and aggression in the NHS.

- The NHS *zero tolerance zone* campaign, with the support of the Home Secretary, the Lord Chancellor and the Attorney General was aimed at increasing staff awareness of the need to report, assuring staff that this issue would be tackled and informing the public that violence against staff working in the NHS was unacceptable and would not be tolerated.

- *Working Together: Securing a Quality Workforce for the NHS,* required Trusts and health authorities to have systems for recording incidents using a standard definition developed by the European Commission, and to set targets for reducing violence and aggression by 20% by 2001 and 30% by 2003. The targets were subsequently incorporated in the *Improving Working Lives* standard, launched in October 2000, which all acute, mental health and ambulance Trusts were required to put into practice by April 2003.[8]

4. On the basis of a follow-up Report by the Comptroller and Auditor General, we took evidence from the Department to determine the extent of improvement in the accuracy of the measurement of violence and aggression in NHS acute, mental health and ambulance

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5   2nd Report from the Committee of Public Accounts, *Health and Safety in NHS Acute Hospital Trusts in England* (HC 350, Session 1997–98)

6   C&AG's Report, para 2.2 and Appendix 1

7   *ibid,* para 1.12

8   *ibid,* para 5

Trusts; and the effectiveness of actions taken to improve the protection and support given to healthcare staff.

Meeting the Department's Working Together targets

5. In 2000–2001, there were some 84,214 reported incidents of violence and aggression against NHS staff, an increase of 30% over 1998–1999. This increase has continued in 2001–2002 with 95,501 reported incidents, a 13% increase over the 2000–01 baseline (**Figure 2**). As a result the 20% National Improvement Target has not been met, with only a fifth of Trusts achieving the 20% reduction.[9]

6. The Department was unable to say whether it was likely to meet the 30% reduction target as the number of reported incidents was clearly going in the wrong direction. While some Trusts, for example Kings, have reduced the number of incidents, for the majority of the NHS the numbers are still going up.[10] However, incidents involving serious physical abuse, which by law have to be reported to the Health and Safety Executive (HSE) under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995, appear to be coming down.[11]

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9   C&AG's Report, case example 8; Q 6
10 C&AG's Report, paras2.7–2.8 and Figure 4; Q 1
11 C&AG's Report, Appendix 4; Qq 2–3

Figure 2: Incidents of violence and aggression

Type of Trust	1998–99 Reported number of incidents of per 1000 staff per month (i)	2000–2001 Reported number of incidents per 1000 staff per month (designated as the baseline) (i)	2001–02 Reported number of incidents per 1000 staff per month (iii)
Acute	3	5	7
Multi-service	9	8	Not applicable (v)
Ambulance	7	13	12
Community/mental health	14	23	Not applicable (v)
Mental health/learning disabilities	24	27	35
All NHS Trusts	7	10	14
Total number of incidents	approx 65,000 incidents	84,214 incidents(ii)	95,501 incidents (iii)
Assaults causing major injury reported to the Health and Safety Executive (iv)	67	82	64
All Assaults reported to the Health and Safety Executive (iv)	766	846	759

(i)   Information derived from Department of Health surveys conducted in 1998–99 and 2000–01the latter of which was designated as the baseline assessment against which the national improvement targets were to be measured.

(ii)   Against a background of significant historical under-reporting of violence, the Department noted that the rise between 1998–99 and 2000–01 was likely to reflect increased awareness of the need to report, and that verbal abuse as well as physical assault was being reported.

(iii)   Information collected by the National Audit Office following a census of all acute, mental health and ambulance Trusts.

(iv)   Information provided to the Health and Safety Executive under RIDDOR on incidents that resulted in more than three days off work The Health and Safety Executive estimates that only 42% of all incidents that should be reported to them are reported.

(v)   NHS Multi Service Trusts and Community/Mental health Trusts are no longer a designated type of Trust as services have been re-configured into either a Mental Health Trust or a Primary Care Trust.

Source: National Audit Office[12]

7. There are wide variations between the numbers of reported incidents in the different types of Trusts with mental health/learning disability Trusts having two and a half times the average number of reported incidents per 1000 staff in 2001–02. Staff working in healthcare are at a higher risk of violence and aggression than most other professions, with nurses up to four times more likely to experience work related violence and aggression than other workers. Ambulance staff have a higher risk than staff in acute Trusts and, within acute Trusts, staff working in the Accident and Emergency Department will

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12   C&AG's Report, Figure 4, p14, and Appendix 4, p44 (Figure)

generally experience the highest number of incidents. There are also wide variations between similar types of Trusts and between different strategic health authorities, with links to violence and aggression in inner cities and other high crime areas. The Department does not currently know the reasons for these variations.[13]

8. Some of the perceived reasons for the overall increase in incidents include better awareness and encouragement of reporting with more widespread use of a common definition, particularly the inclusion of verbal abuse, but also increased hospital activity, higher patient expectations and frustrations due to increased waiting times. The Department also felt that part of the reason was a tendency to greater abuse and violence in society as a whole.[14]

9. However, other than the data held by the Health and Safety Executive (paragraph 6), there is no central information on the types or characteristics of incidents. The Department could not distinguish between levels of serious, verbal and physical abuse. Nor was information collected as a matter of routine on the extent to which alcohol and drug misuse was involved, or the degree to which incidents involved patients suffering from mental or physical illness, or those which might be gender or racially motivated. The Department said that there were research studies into some of these issues and that some information might be held at local level by NHS employers.[15]

The validity of the figures reported under "Working Together"

10. Following the recommendations in our predecessor's report, NHS Trusts were encouraged to improve their reporting systems, but it was left to individual Trusts to determine the best reporting systems for their local circumstances. Four fifths of Trusts now use an integrated computerised reporting system covering clinical and non-clinical risks. However the types of systems vary and there are inconsistencies and confusion over what and how to report. The zero tolerance zone campaign has done a lot to encourage reporting and appears to be one of the main reasons for the increase in reported incidents. Nevertheless, many NHS Trusts believe that staff are less likely to report violence and aggression than any other health and safety incident.[16]

11. 90% of Accident and Emergency Departments highlighted under-reporting as a problem (the average estimate being 39%), a point that has been confirmed by various staff surveys. Reasons include staff perceptions that they would be seen to have failed and/or mishandled the situation or that it could be regarded as professional incompetence. The Department agreed that managers needed to address this problem. They emphasised that through communication of the policy of zero tolerance, supported by appropriate risk assessment and training, Trusts should be providing an environment where staff did not feel guilty if they were the subject of violence, but also knew how to deal with it when it did occur.[17]

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13   C&AG's Report, paras 1.4 , 2.9–2.10 and Figures 1, 4–5; Qq 1, 50–52, 74–75, 86, 71, 98

14   C&AG's Report, paras 2.14–1.15; Qq 4–6

15   Qq 2–3, 38–47, 86, 89–93; Ev 12

16   C&AG's Report, paras 2.13, 2.16, 2.18–2.21; Q 7

17   C&AG's Report, paras 2.16–2.17; Qq 23–25

12. The extent to which employers are tackling zero tolerance is now an element of the Improving Working Lives star rating system under which Trusts are subject to annual, independent inspections which include surveys of staff groups to obtain their views of how well their employers are implementing the policy. These surveys have not produced any evidence that staff are still being discouraged from reporting incidents.[18]

13. The Department's own survey in 1998–99 found that employers were using different definitions of violence and aggression. In particular, large numbers of Trusts were not including incidents of verbal abuse in their reported statistics. As part of the Working Together and zero tolerance initiatives, they recommended that Trusts should, by April 2000, adopt the standard European Commission definition of violence.[19] Despite this guidance, over 20 different interpretations were still in use at the time of the National Audit Office survey. In the next phase of the zero tolerance zone campaign the Department intended to use the opportunity presented by the National Audit Office report to stress again the importance of adopting the European definition. The aim is to be able to rely on the trends in data as being evidence of what is happening in reality, rather than what is happening in measuring.[20]

14. The Department has established a new Special Health Authority, the Counter Fraud and Security Management Service, which from April 2003 will be leading a programme of work to implement the recommendations contained in the National Audit Office report. Its remit includes introducing a strengthened national reporting system to record incidents of violence and aggression against staff using a common definition with the ability to track cases through to conclusion. It is intended that the new system, which is to be in place by September 2003, will be able to report separately on different types of violence and aggression and be able to differentiate between, for example, verbal abuse and physical assault.[21]

Measuring the cost and impact of violence and aggression

15. Our predecessor Committee found little information on the costs to the NHS of health and safety incidents involving staff. The Department confirmed that they remain a long way from having reliable cost measures, although some data exist on the cost of temporary staff to cover sickness absence. The Department will be considering what more can be done in the light of the National Audit Office's report.[22]

16. There is also a lack of information on the impact of violence and aggression on staff. One source of such information could be staff exit interviews, but exit interviews do not ask staff specifically whether they are leaving as a result of violence and staff do not

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18   Qq 13–15, 16, 66

19   Any incident where staff are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well being or health—European Commission DG V 1997

20   C&AG's Report, paras 2.4, 3.11; Qq 9, 58

21   C&AG's Report, para 22; Q 83; Ev 12

22   2nd Report from the Committee of Public Accounts, *Health and Safety in NHS Acute Hospital Trusts in England* (HC 350, Session 1997–98); C&AG's Report, para 2.24; Qq 59–64

spontaneously mention violence as a major contributory factor. The Department said that it needed a better understanding of how many people leave as a result of violence.[23]

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2 Actions to deter violence and aggression

Understanding the reasons in order to target interventions

17. There are many reasons why patients and visitors to hospitals may turn to violence and aggression. They may be under considerable stress, concerned about their own injury or that of a close relative, they might be confused or disorientated because of their physical or mental condition. They may be under the influence of drugs or alcohol, or they might be frustrated by having to wait in unpleasant surroundings with inadequate information.[24]

18. In response to our predecessor Committee's report the Department recommended that Trusts should evaluate the health and safety risks to staff. In 1998, NHS guidance stated that while there were no well worked out and validated systems of risk assessment solely for work-related violence, general risk assessment strategies and procedures and a sound understanding of the nature of violent incidents would enable Trusts to design one. Guidance from the Health and Safety Executive has also reinforced the need for Trusts to use risk assessments to help understand, identify and prevent violence and aggression.[25] The Department emphasised that risk assessments are a matter for local management, who use them to identify, among other things, a profile of the hours of the day when staff are most at risk and the need for specific security measures.[26]

19. The Department has recognised that there is a significant problem in accident and emergency departments and has taken specific steps to tackle this, firstly by reducing waiting times and also by introducing "Modern Matrons" into every department to ensure that patients are treated decently, in a clean environment which has adequate facilities. Matrons have each been given a budget of £10,000 to sort out specific problem areas. Many accident and emergency departments also have arrangements with psychiatric services so that patients displaying mental health problems can be appropriately handled to minimise the risk to staff. A number have introduced separate areas specifically for children, and have enhanced their information systems and the provision of refreshments.[27]

Enhancing the security measures

20. Trusts have taken a range of measures to improve staff safety, by using new technology and introducing specific security measures such as swipe card access systems and central locking on ambulances. Under the Improving Working Lives Initiative, the Department has set aside £1.5 million for new initiatives over three years, to be matched by £1.5 million from Trust funds. In addition, a number of schemes funded under the Department's £150 million accident and emergency modernisation programme have been used to bring about improvements in security for staff and patients, for example the installation of closed

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24   C&AG's Report, paras 18, 3.34–3.36; Qq 4–5, 17, 86

25   C&AG's Report, para 3.5–3.7; Q 25

26   C&AG's Report, para 3.8–3.9; Qq 73, 76

27   Qq 4 –5, 17, 51, 56–57, 78, 88–89, 92

circuit television facilities and equipping nursing staff with personal alarm systems.[28] Ambulance crews may be dispatched to an incident with limited information on the nature of the situation they are likely to face. Ambulance Trusts now use electronic flagging of known dangerous areas; have procedures for withdrawing from the accident scene at the first threat of violence; and are testing the use of CCTV cameras in their emergency vehicles. The London Ambulance Service had achieved some success in reducing incidents as a result of such measures, and the Royal Berkshire Ambulance Trust was another example of good practice.[29]

From warning letters to withdrawal of treatment

21. There is an escalating series of interventions available to Trusts to deter violent and abusive behaviour. The zero tolerance campaign includes written warnings to patients (yellow cards) culminating in withholding treatment (red cards) from patients who are repeatedly violent or abusive. The Department's guidance exempts patients who are mentally ill and may be under the influence of drugs and/or alcohol, though they are often the prime cause of incidents. The Department said that this intervention could be an effective measure in a busy accident and emergency department. The Kings College Hospital had such a scheme which had been widely publicised in the NHS as an example of good practice[30]

22. Withholding treatment is a last resort and in practice Trusts are more likely to use warning letters from the ward or department in which the violence occurred or from the Chief Executive, pointing out that the patient's or relative's behaviour is unacceptable.[31] NHS Trusts that use warning letters generally consider them to be successful in bringing home to perpetrators that violence will not be tolerated, and believe that they have achieved improvements in behaviour. We asked whether the Department had considered a system whereby the patient or visitor who had been violent was brought face to face with their victim to show the effect of the violence and how damaging it could be. While this practice has not been applied systematically across the NHS, some Trusts send letters to perpetrators which include an invitation to come into the hospital to give their side of the story.[32]

Security Officers and a police presence can act as a deterrent

23. The National Audit Office report found that while visible technology and security measures might not always be appropriate, staff felt that the employment of security staff or a visible police presence acted as a deterrent. While there is little direct evidence of the effectiveness of such measures, between 20 and 40% of Trusts, particularly with inner city accident and emergency departments, are using them. Other Trusts have installed hot lines to police stations and in the case of ambulance Trusts, are making co-ordinated visits to potentially dangerous locations.[33]

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28 C&AG's Report, paras 3.28 –3.33; Qq 4, 70, 72–73, 92

29 C&AG's Report, case example 1 and Figure 14; Qq 17–18, 94–95

30 C&AG's Report, para 3.39; Qq 8, 47, 93

31 C&AG's Report, para 3.37–3.39; Qq 20, 47

32 C&AG's Report, para 3.40; Q 96

33 C&AG's Report, paras 3.34 –35, 3.42–43, Figure 14 and case examples 8–9, 11; Qq 18–19

3 Helping staff deal with violence and aggression

Appropriate policies for addressing safe working conditions can secure staff confidence

24. A recent comparison of the guidance available in the United Kingdom, Australia, Sweden and the United States of America described the Department's commitment to reducing the risk of violence as the most elaborate compared to other countries. The review concluded that there was no single guideline to promote as best practice, but that the *zero tolerance zone* campaign was the most comprehensive approach. The zero tolerance guidance encourages Trusts to secure the confidence of their staff and demonstrate their support by issuing a policy document addressing safe working conditions. Most Trusts have developed their own policies or were developing one following re-organisation. The majority of these Trusts had involved staff in drawing up the policy although only a third of Trust had subjected them to legal review. [34]

Effective education and training provides essential protection to staff

25. Departmental guidance highlights the importance of staff knowing how to recognise and respond to potential and actual threats and recommends that Trust should determine training needs by assessing the risks faced by different types of staff. Such training should be "up-to-date, relevant, purposeful, backed by expert guidance and include feedback". Research commissioned by the Department found no clear direction or evidence base on which staff training needs were assessed. Training programmes were largely 'off the shelf' and the syllabuses were based more on the experience and preference of the trainers that a rational analysis of training needs. As regards delivery of courses, a growing number of training organisations are providing violence and aggression training with no system of accreditation or guidance on what is effective. There is also limited research into the safety and effectiveness of the different methods. [35]

26. The Department told the Committee that staff training had improved since our earlier report, but acknowledged that there was no national guidance and that further work was required to ensure that good quality training was available generally. They noted that, as the next phase of zero tolerance, the Counter Fraud and Security Management Services would be accrediting higher quality training organisations to make sure that the training was of good quality. [36]

Support and counselling provided to NHS staff

27. Departmental guidance issued to Trusts in 2002 emphasises that counselling services should be available to staff who report an incident of harassment in the workplace, but also

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34   C&AG's Report, para 3.10–3.12, 3.51; Qq 22, 58
35   C&AG's Report, paras 3.15 –3.23 and Figure 11
36   Qq 24 –27, 44

that counselling should only be offered after an assessment has been made of its likely benefits, as poor services or those used inappropriately can do more harm than good. The provision of counselling to staff that have been physically assaulted is limited, with only 20% of nurses who had been assaulted being offered counselling. The Department agreed that the proportion should not be so low and expected to see all Trusts offering counselling services to everyone affected by an incident.

Partnership working

28. When the zero tolerance zone campaign was launched it was recognised that the problem of violence and aggression was not one that the Department could solve on its own, so it was launched with the support of the Home Office, the Crown Prosecution Service and the Attorney General. New sentencing guidelines were issued to all magistrates' courts on the subject of prosecutions. Many Trusts have developed closer working relations with the police, but while the Department has stressed the need for Trusts to co-operate more with local Crime and Disorder Reduction Partnerships, the NHS has not universally made best use of this opportunity. The new Counter Fraud and Security Management Service will be seeking to establish a Memorandum of Understanding with the Association of Chief Police Officers that sets out what the NHS can expect from the police and what they can expect from the NHS. They are discussing similar arrangements with the Crown Prosecution Service.[37]

Prosecuting the perpetrators of violence and aggression

29. Neither the Department nor the Crown Prosecution Service holds information on police prosecutions. The National Audit Office survey and literature searches confirmed that prosecutions are rare and that sentencing is often perceived to be light. In the event that the police or the Crown Prosecution Service decides that they are not able to prosecute, it will generally be up to the Trust or individual who has suffered the violence to bring a civil action. Trusts are often reluctant to bring prosecutions and most provide only limited support to staff, with 30% providing none.[38]

30. The Department did not have accurate figures on the number of prosecutions by Trusts or of civil actions taken by staff. In April 2003 the Department asked the four Health and Social Care Regions of the NHS for information on Trust prosecutions over the previous eight months. **Figure 3** shows regional differences in the numbers of prosecutions and overall that there were 51 prosecutions by Trusts and 6 prosecutions supported by Trusts. The Department considered that this variation reflected different approaches rather than differences in the geographical spread of violence and acknowledged that it needed to do more work in this area. The Department anticipates that the number of prosecutions will increase as responsibility is taken over by the NHS Counter Fraud and Security Management Service, which they believe will be more equipped to deal with evidence collection and other issues relating to prosecutions.[39]

37   C&AG's Report, Figure 3, paras 19, 3.41–3.43, 3.49, 3.52 and case examples 5, 10–11; Qq 30–31, 80–85; Ev 12

38   C&AG's Report, para 3.44–3.46; Qq 19, 67, 80–81

39   Ev 12; Qq 22, 28–30, 98

Figure 3: Department of Health survey of actions taken by Trusts by region

Department of Health and Social Care Region	Prosecutions by Trusts	Prosecutions supported by Trusts
London	13	3
South	20	1
Midlands & East	3	0
North	15	2

Source: Department of Health press statement issued 27 March 2003

Conclusions and recommendations

1. The Department and the new Counter Fraud and Security Management Services should introduce a strengthened national mandatory reporting system based on a common definition, which differentiates between types of incidents and captures information on the underlying causes and characteristics of each incident.

2. The Department, through strategic health authorities, should agree with each Trust chief executive realistic targets for reducing violence and aggression. In turn, each Trust should adopt a health and safety management strategy which addresses the most serious risks. There needs to be clarity as to how the local target fits with national improvement targets and compliance should continue to be monitored as part of Improving Working Lives.

3. All healthcare workers should be made aware of the risks of violence and aggression early in their careers, so that reporting and compliance with best practice is second nature, including the need to comply with Health and Safety Executive statutory reporting requirements. This initial awareness should be re-enforced through targeted training activity. The Department and Counter Fraud Security Management Services should work with the NHS University to develop a standardised induction programme; and accredit good quality training providers to provide continuing professional development training based on Trusts' annual training needs assessments.

4. The Department should work with the Health and Safety Executive and NHS Litigation Authority to develop a robust costing model which provides a clear overview of the costs and impact of violence and aggression. Trusts should be encouraged to use this model in developing a business case for investment in counter-measures

5. The Department lacks robust evidence of the effectiveness of interventions and counter measures to reduce and prevent violence and aggression. The Department should commission research to generate evidence of the impact of various interventions such as improvements to the environment including the impact of the Modern Matron, the deterrent effect of withholding treatment, and the introduction of specific security measures.

6. The Department needs to ensure that Trusts provide sufficient support to staff that have been affected by violence and aggression. It should encourage Trusts to adopt a consistent approach, including access to counselling where appropriate, issuing warning letters, supporting staff in undertaking civil action, and providing feedback to staff on outcomes.

7. The new Counter Fraud Security Management Service should expedite the Memorandum of Understanding with the Association of Chief Police Officers and develop a similar understanding with the Crown Prosecution Service. Likewise their proposals to improve the support given to staff to pursue private prosecutions should be promptly implemented.

Formal minutes

Wednesday 2 July 2003

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon   Mr Brian Jenkins
Mr Ian Davidson   Mr David Rendel
Mr Frank Field

The Committee deliberated.

Draft Report (A safer place to work: Protecting NHS hospital and ambulance staff from violence and aggression), proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 30 read and agreed to.

Conclusions and recommendations read and agreed to.

Summary read and agreed to.

Resolved, That the Report be the Thirty-ninth Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Ordered, That the provisions of Standing Order No. 134 (Select Committees (Reports)) be applied to the Report.

Adjourned until Wednesday 10 September at 3.30 pm

Witnesses

List of written evidence

List of Reports from the Committee of Public Accounts
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First Report	Collecting the television licence fee	HC 118	*(Cm 5770)*
Second Report	Dealing with pollution from ships	HC 119	*(Cm 5770)*
Third Report	Tobacco Smuggling	HC 143	*(Cm 5770)*
Fourth Report	Private Finance Initiative: redevelopment of MOD Main Building	HC 298	*(Cm 5789)*
Fifth Report	The 2001 outbreak of Foot and Mouth Disease	HC 487	*(Cm 5801)*
Sixth Report	Ministry of Defence: Exercise Saif Sareea II	HC 502	*(Cm 5801)*
Seventh Report	Excess Votes 2001–02	HC 503	*(N/A)*
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