National Assembly for Wales
Audit Committee

Protecting NHS Staff from Violence and Aggression

July 2009

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Protecting NHS Staff from Violence and Aggression

July 2009

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Chair's Foreword

Violence and aggression against staff in the NHS in Wales is a serious problem. The Audit Committee last reported on this in 2006 and expressed concerns about a number of issues including the failure of staff to report many incidents of violence and difficulties in recording the data so that an overall picture could be obtained. The Committee was also concerned about training, about improving the environment for staff in potentially violent situations, and about improving relationships with the police and the level of prosecutions.

Almost 3 years later the Auditor General has published an updated report which concludes that while some progress has been made there are still problems that need addressing. In preparing its report the Committee has taken evidence from representatives of staff groups in order to obtain a fuller and first hand picture of the situation. It finally took evidence from the Director General for Health and Social Services and Chief Executive of the NHS in Wales who is the Accounting Officer.

The Committee agrees and endorses the Auditor General's recommendations and has urged the Government to expedite work on the recommendations made by the Auditor General. The Audit Committee has also asked the Government to provide an update on progress by the end of the year so that it can review the progress that has been made.

Jonathan Morgan
Chair, Audit Committee

Summary of Conclusions and Recommendations

1. The Committee notes that the Auditor General does not make any specific recommendations in his latest report and the Committee's main and important conclusion is that greater priority and urgency should be given to all these issues. **The Committee recommends that the Welsh Assembly Government expedites work on all the items identified by the Auditor General.**

2. **The Committee further recommends that the Welsh Government in addition to its usual response to this report provides an update on progress at the end of this year by which time it should be able to demonstrate that all the action dependent on the new LHBs being in place should have been implemented and is showing results.**

Introduction

This report is presented to the National Assembly for Wales under Standing Order 13.2 which states

13.2 The Committee may:

(i) consider and report to the Assembly in accordance with section 143(1) of the Act on documents laid before the Assembly by the Auditor General or that officer's auditor; and

Background

1. Violence and aggression in the NHS is a serious problem. In March 2006 the Audit Committee reported on the action being taken by the Welsh Assembly Government to protect NHS staff from it. This was based on a report by the Auditor General for Wales and on oral evidence from the Head of the Welsh Assembly Government's Health and Social Care Department and Chief Executive to the NHS, and from the Chief Executive of Conwy and Denbighshire NHS Trust and Accounting Officer for the Welsh Risk Pool. This report made various recommendations to the government in respect of its handling of this matter.

2. In February 2009, the Auditor General published a further report which had been undertaken in order to examine the progress that had been made since 2006. The Auditor General told the Committee that he was not following this subject up just as a matter of routine but because members of the Committee had been extremely concerned about the situation in the earlier reports.

3. The Auditor General presented his report to the Committee at its meeting on 25 February 2009 and the Committee concluded that it wished to

investigate these issues further. Accordingly, it decided to take evidence from representatives of staff groups (Unison, the British Medical Association and the Royal College of Nursing) and the authorities involved in responding to violence and aggression (the Crown Prosecution Service and the Association of Police Officers). Subsequently, the Committee took evidence from the Chief Executive of the NHS in Wales and senior officials.

4. The witnesses who gave oral evidence were:

25 March 2009

- Dr Richard Lewis, Welsh Secretary, British Medical Association, Cymru Wales
- Lucy Merredy, Research & Policy Officer, British Medical Association, Cymru Wales
- Dave Galligan, Head of Health, Unison
- Tina Donnelly, Director, Royal College of Nursing, Wales
- Lisa Turnbull, Policy Advisor, Royal College of Nursing
- David Wallace, Professional Officer, Royal Collage of Nursing

25 March 2009

- Chris Woolley, Chief Crown Prosecutor for South Wales
- Barbara Wilding, Association of Chief Police Officers

30 April 2009

- Paul Williams, Head of Health and Social Services, Welsh Assembly Government
- Sheelagh Lloyd-Jones, Director of Human Resources, NHS Wales
- David Francis, All Wales Champion against Violence and Aggression against NHS Wales staff

Issues

5. The Auditor General's broad conclusion in his 2009 report was that good progress had been made in tackling this difficult issue but there were still areas on which more work was needed. He identified three broad areas of concern:

    a. The Assembly Government and health bodies are improving their systems for collecting and monitoring data on incidents, but under-reporting is still a problem

    b. Health bodies have implemented some actions to prevent and control violent incidents but many are still not in place

    c. The Assembly Government, health bodies and other partners are developing better ways to support staff after incidents

Reporting of violence and aggression

Underreporting

6. The witnesses from all the staff groups agreed that non-reporting was an issue. Mr Galligan[1] said that underreporting has developed over a long period and is almost a self fulfilling prophecy. As for the reasons, they said that people do not believe anything happened as a consequence of reporting. The Dr Lewis[2] concurred with this saying people do not wish to come forward and that people do not feel enough is being done when they go through the process of reporting an incident. Their perception was that the perpetrators of the offence are not taken to court and there is no outcome. Ms Donnelly echoed these views[3] adding that completing an incident form is a long drawn-out process which frequently has to be done

[1] Record of Proceedings AC(3)-05-09 [12]
[2] Record of Proceedings AC(3)-05-09 [14]
[3] Record of Proceedings AC(3)-05-09 [17]

at the end of a very busy shift, and that after being on the receiving end of violence, you are less likely to want to go through such a process.

7. Mr Woolley said[4] that they too had identified that there is considerable reluctance among staff to report violence. Their research echoed the reasons given above. They added that consideration of the staff-patient relationship could be a factor as could and an acceptance of harm as being part of the job. In a similar vein, Ms Wilding said that staff regularly confronted by violence can come to accept it as part of the job and not report it.[5]

8. The Committee found it difficult to reconcile these views with the view from Mr Williams[6] that the number of serious assaults across the NHS appears to be stabilising while the number of reported incidents was increasing. He referred to a figure of 7,800 incidents of violence and aggression being reported in 2007-8 and that this number had apparently fallen in 2008-9 to 6,950 – but added that these numbers should be treated with some caution 'because of reporting'.[7]

Data and coding of it

9. The Committee noted the improvements that had been made in the collection of data and that a common set of codes had now been agreed. In his oral evidence[8] Mr Williams reported that 50 percent of organisations have made progress and the others have a lot to do. In his subsequent note to the Committee, Mr Williams reported that trusts are currently using different versions of Datix to record incidents, claims and complaints and that, by October 2009, they will all have updated their current systems to the most up-to-date version of Datix. The significance of October 2009 is that this is the date when the new Local Health Boards (LHBs) will be established. This is a welcome and essential development but, the Committee is disappointed that it has taken so long to achieve this. This date is also still a few months away and there is still a lot to be done while

[4] Record of Proceedings AC(3)-05-09 [117]
[5] Record of Proceedings AC(3)-05-09 [122]
[6] Record of Proceedings AC(3)-06-09 [13]
[7] Record of Proceedings AC(3)-06-09 [14]
[8] Record of Proceedings AC(3)-06-09 [24]

past performance does not give grounds for confidence. Moreover, while reorganisation of the NHS is relevant, it will not in itself ensure the target is met.

Board champions

10. One of the key aspects of improving the handling of violence and aggression is the appointment of Board 'Champions' to monitor performance and review incidents. Mr Williams[9] [rop2/18] said that having a board champion regularly reporting to the board would make staff aware that the matter is at the top of the agenda. The Auditor General reported that all trusts had now designated a senior member of staff in this way. The Committee asked how the 'new' champions differed from those reported on in 2005 at the time of the previous inquiry but Mr Francis[10] [rop2/41] was unable to comment on the 2005 senior member of staff and could not say what it was like at that time. The Committee is surprised that these appointments are being seen as 'new' initiatives and are not building on the experiences of the 2005 appointments and lessons learned from them. This seems a wasted opportunity.

Action plans

11. It is reassuring that there is an All Wales template in place for all Trusts and LHBs to draw up action plans to address the action required to protect staff from violence and aggression. Mr Williams, in his further evidence, said that there was a requirement that by October 2009 all new LHBs will be operating to a single plan. This is a welcome development but, again, seems to rely on NHS reorganisation as being the answer to all these problems.

Conclusion

12. The Committee finds it unacceptable that in the three years since its last Report, staff reporting of incidents of violence and aggression is still

[9] Record of Proceedings AC(3)-06-09 [18]
[10] Record of Proceedings AC(3)-06-09 [41]

inadequate. The reasons for a lack of reporting were known in 2006, the importance of having sound data is accepted by everyone - but the data themselves are still inadequate. The Committee finds it difficult to understand how management can conclude that the numbers of serious physical assaults across the NHS is stabilising when the number of reported incidents is showing an increase. Put another way, while it might be correct that the increase is due to improved reporting, it is difficult to see how one can confidently come to that conclusion when the information on reporting is so unreliable. The Committee notes that there is a requirement that by 1 October 2009 all new LHBs will be operating to a single plan but this is very little progress after three and a half years.

Action to prevent and control violent incidents

13. The Auditor General has reported that health bodies have implemented some actions to prevent and control violent incidents but many are still not in place. He referred to the launching of the Training Passport in 2005 but said that some issues still remained. Similarly, action has been taken to improve the environment for workers but the arrangements for lone workers are still not always satisfactory.

Training

14. Staff training is a key element in preventing and controlling incidents. Mr Williams was uncertain in his oral evidence about the number of staff who still required training[11] and about the requirement on trusts to report. However, in a subsequent note to the Committee[12] he said that all trusts in Wales currently provide training in line with the All Wales Violence and Aggression training Passport and had mechanisms for monitoring the amount of staff trained as a percentage of those staff requiring training identified through a training needs analysis.

[11] Record of Proceedings AC(3)-06-09 [64]
[12] Letter 30 April 2009 to Audit Committee Clerk

15. The staff group witnesses agreed that training was available in NHS Trusts although there was perhaps an insufficient roll out to LHBs and primary care.

16. However the key issue seems to be the release of staff[13]. In part this appears to reflect the large numbers of staff who need the training[14] but, conversely, the magnitude of the need ought to make it a priority. Staff groups reported that there was a general willingness in principle amongst management to make staff available for training but the problem[15] [rop1/ 61,62] was releasing staff on the day – particularly because of the need to back fill with agency or bank staff and this involved a cost.[16]

17. Again the Committee is concerned that this evidence suggests that management attaches a low priority to training. Mr Williams said[17] that providing training was difficult in terms of releasing staff and making staff available because of service pressures. He referred to maybe a 40 per cent did-not-attend rate and they had introduced things like an e-learning package to cope with this

18. The Committee was also concerned that alongside there seemed very little information about the number of staff who had undergone or who needed training.[18] Mr Williams talked only in general terms about the importance of training and the need to undertake risk assessments to identify priorities – but alongside this there were reservations about[19] the appropriateness of some of the training and about the lack of progress developing Modules C and D.

19. In his subsequent letter, Mr Williams said that all Trusts have given assurances that information on the number of staff who have undergone or needed training will be available when the new LHBs take effect in October 2009. Given that this has been an issue since 2005 this again seems to

[13] Record of Proceedings AC(3)-05-09 [61, 62]
[14] Record of Proceedings AC(3)-05-09 [61, 62]
[15] Record of Proceedings AC(3)-05-09 [61, 62]
[16] Record of Proceedings AC(3)-05-09 [62]
[17] Record of Proceedings AC(3)-06-09 [65]
[18] Record of Proceedings AC(3)-06-09 [64]
[19] Record of Proceedings AC(3)-06-09 [69]

confirm the low priority attached to these issues. And, again, that reliance is being placed on NHS reorganisation as being the answer to all these issues.

20. The Committee concludes that the general approach is still too casual. Training staff in ways to prevent and control violent incidents is an important part of the policy but its implementation seems to be very half-hearted. While, inevitably, there are costs associated with releasing staff to undergo such training, the alternative of managing the consequences of violence and aggression also incurs costs and resolving these issues should be seen as a good investment.

CCTV

21. One of the concerns in relation to low levels of staff reporting was the difficulty in obtaining prosecutions. The Health Minister's Ministerial Task Force reported that the use of good quality CCTV cameras would allow for better detection and the prosecution of perpetrators and recommended that a national initiative was undertaken to provide CCTV within A & E departments in all large hospitals. While 17 hospitals now have CCTV cameras it is disappointing that only 3 of these were considered to be of good enough quality to provide evidence to be used in a prosecution. The Committee was reassured that the Crown Prosecution Service said they would consider images of any quality to see whether anything can be obtained from them[20] and that the police would send the images to a laboratory to see if they can be enhanced.[21] They noted also that the new equipment was very good.

22. Mr Williams told the Committee that pilots were already underway on high quality closed-circuit television on four trust premises.[22] The Committee noted Mr Williams' comments that trusts had probably not invested in catching up with technology and that the situation had reached intolerable levels in some places. He noted that this investment meant they had to

[20] Record of Proceedings AC(3)-05-09 [156]
[21] Record of Proceedings AC(3)-05-09 [157]
[22] Record of Proceedings AC(3)-06-09 [82, 83]

divert money from front line healthcare.[23] The Committee notes that, while this might be the case, the statement seems again to ignore the costs associated with staff being off work as a consequence of incidents of violence and aggression. Nor can this be used as an excuse by the NHS not to invest in ways to protect and support frontline staff. It is also disappointing that there is no established basis on which LHBs can judge the relative costs and benefits of such investments.

Lone workers

23. The Auditor General's report refers to the particular risks faced by lone workers such as community midwives and district nurses. Work was in hand at the time of the last report to develop a lone worker tracking scheme but in 2006 the Assembly Government decided that this was a matter for trusts to pursue. They have now come to a different view and are developing a business case to secure funding for such a scheme. The Committee recognises that it is important to ensure that such a system is effective for the risks faced by NHS staff and can see the logic now in pursuing a system alongside colleagues in England if this is appropriate for Wales. Nonetheless, it is disappointing that so little progress seems to have been made since 2005 and lone workers are still not benefiting from the protection of a tracking system.

Conclusion

24. Again the Committee is disappointed that while a need to address this issue has been identified for a long timed, action to move things forward seems very half-hearted. Preventing and controlling violent incidents must be seen by the NHS as a priority and we are not convinced that sufficient progress has been made since the report in 2006.

[23] Record of Proceedings AC(3)-06-09 [92]

Supporting staff in relation to violent incidents

25. The Auditor General's report found that some progress had been made in developing better ways to deal with incidents of violence and aggression although not every authority had security staff available to help when an incident occurs.

Security staff – police presence

26. There is an inevitable difficulty in relation to the provision of security staff or a response to violent incidents because it is not always possible to know where a violent incident might arise and the need for a response is immediate. Technology can help but only provided it is the right technology. Concerns were also raised by those who gave evidence from the Unions that many Security Staff were temporary and privately contracted, often receiving little training for their specific role as Security Staff in a Hospital or health care setting. The Auditor General's report stated that some trusts were unhappy with the response of the police[24] and that some trusts had started working with the police in setting up local arrangements. The Task Force found[25] that where the police were sited in A & E departments, there was a significant decrease in violent incidents. But there is a resource issue here.

27. Ms Wilding said that from the police perspective the issue was one of balancing demands. They did not have a resource for every second of every minute of the day and so they could not have police officers in A & E departments in hospitals.[26] However, where 50 per cent of the cost of a police community support officer is paid for then duties would be organised around that.[27] (1/177) She also said that police were often in A & E departments because they had taken people to hospital for treatment because of an incident elsewhere.

[24] AC(3)-05-09 (p1) para 3.3 Protecting NHS Staff from Violence and Aggression – An Update
[25] AC(3)-05-09 (p1) para 3.5 Protecting NHS Staff from Violence and Aggression – An Update
[26] Record of Proceedings AC(3)-05-09 [175,176]
[27] Record of Proceedings AC(3)-05-09 [177]

28. The view from Unison was that a police presence was not always beneficial because the police were "frequently reluctant"[28] to take any action at all for whatever reason. From a hospital perspective there was also a problem of having security in the right place because a violent incident could occur anywhere in the grounds.[29] This clearly is a complex issue and the Committee notes that there has been a substantial improvement in the way that trusts work with the police. However, it was disappointed that while work had been going on to develop a Memorandum of Understanding between the Welsh Assembly Government and the police this had still not been signed.

Memorandum of Understanding

29. In his report, the Auditor General said that a Memorandum of Understanding between the Assembly government and the four Chief Constables in Wales has been drafted but not yet agreed. Mr Williams said that the issue had been around the discussion and getting the organisations together.[30] Mr Francis said[31] that a draft had been available as long as a year ago and when he was appointed he asked to revisit it as he felt it was far too broad. The Committee finds it difficult to understand how, if the MOU is significant to the resolution of these issues, it can take so long to reach agreement on it. This again seems evidence of a very low priority being attached to these issues, which in our view is unacceptable.

Low level of prosecutions

30. One of the reasons given for staff being reluctant to report incidents of violence is the view that nothing happened as a consequence of reporting. Staff groups referred, in particular, to the lack of prosecutions. The CPS said that 'anecdotally' they had seen an increase[32]. They said the information was 'anecdotal' because cases of violence against health service staff were not identified explicitly in the statistics.[33] However, the

[28] Record of Proceedings AC(3)-05-09 [82]
[29] Record of Proceedings AC(3)-06-09 [104]
[30] Record of Proceedings AC(3)-06-09 [112]
[31] Record of Proceedings AC(3)-06-09 [113]
[32] Record of Proceedings AC(3)-05-09 [124]
[33] Record of Proceedings AC(3)-05-09 [127]

CPS treated all cases on the basis of two tests: first, whether there was sufficient evidence to prosecute and whether it was in the public interest to do so.[34] Mr Woolley felt that the latter was not an issue in the overwhelming majority of these offences but what they were concerned with was whether the evidence was there. The CPS had successfully completed two prosecutions in January for assault against NHS staff in the south Wales area and there were three cases ongoing from all parts of south Wales. The Committee noted the contrast with Mr Williams' figure for all of Wales that there were some 6,950 incidents of violence and aggression in 2008/09.

Change to the law

31. The staff group witnesses were generally of the view that there should be a change to the law to make it a specific offence to assault the emergency services or accident and emergency staff. Unison qualified this by saying that the real issue is the current legislation not being applied. And while such a law might give workers confidence and encouragement to report incidents, they would really need to see it working in practice. Considerations of this kind are not devolved matters, but this may be a matter for the Health Minister to investigate further in light of evidence from the Unions who clearly support a change to the law. The key point, with which all witnesses agreed, is that the existing law should be applied fully.

Case workers

32. The Committee notes the widespread support for the availability of case workers to support staff who have suffered from violence. Mr Williams said these should be available to individual members of staff from the moment the incident happens and right through. They would be able to deal with the staff member's personal medical and other needs to help get over the incident. He thought that by working closely with the police and Crown Prosecution Service this would also increase the number of prosecutions. Staff groups welcomed this initiative. The Committee notes the further benefit to the NHS from this investment, similar to that in

[34] Record of Proceedings AC(3)-05-09 [138]

relation to training, as a result of saving the cost of staff being off sick for long periods of time.

Conclusion

33. The Committee notes that again there seems a general lack of priority being given to these issues. The very low rate of prosecution compared to the number of incidents is a cause for concern which might explain why staff can be reluctant to report incidents.

Overall Conclusions and Recommendations

34. It is just over three years since the Committee reported first on the need to protect NHS staff from violence and aggression. In that time some progress has been made. Systems are being developed for recording incidents of violence and aggression against NHS staff and to provide data on a consistent basis. Systems to provide training for staff are being developed and implemented. Efforts are being made to help the NHS work more closely with the police and the CPS and Memoranda of Understanding have been developed.

35. However, there is still a long way to go and in three years only limited progress has been made. The Committee is concerned that:

- staff reporting is still so inadequate that it is difficult to place reliance on the information collected on the number of incidents;
- there is still a significant number of staff requiring training;
- the reason for the lack of training appears to be the lack of priority attached to releasing staff, or an unwillingness to fund cover for this;
- there are still doubts about the appropriateness of some of the training and a lack of progress in developing Modules C and D.
- CCTV systems of an adequate standard are still not in place;
- a lone worker monitoring system is still not in place;

36. Alongside this it seems that there has been a general lack of urgency given to this important issue and it was disappointing that the main response from health management seemed to be that this would all be fine in October, following NHS reorganisation, without any evidence to back this up

37. The Committee notes that the Auditor General does not make any specific recommendations in his latest report and the Committee's main and important conclusion is that greater priority and urgency should be given to all these issues. **The Committee recommends that the Welsh Assembly Government expedites work on all the items identified by the Auditor General.**

38. The Committee further recommends that the Welsh Government in addition to its usual response to this report provides an update on progress at the end of this year by which time it should be able to demonstrate that all the action dependent on the new LHBs being in place should have been implemented and is showing results.

Mr Paul Williams OBE
Director General, Department for Health & Social Services
Chief Executive, NHS Wales
Cyfarwyddwr Cyffredinol, Adran Iechyd a Gofal Cymdeithasol
Prif Weithredwr, GIG Cymru

Eich cyf/ Your ref: 8 May 2009
Ein cyf / Our ref: PMW/

Dear

Re: Evidence given to Audit Committee on 30 April 2009

I am grateful to the Audit Committee for being given the opportunity to present oral evidence last week. This said, on reflection, I was left with the feeling that the answers given to several questions may not have been sufficiently clear. These areas related to,

- Quality of national and local action plans.
- Availability of data regarding proportion of NHS staff trained under the Passport Scheme.
- Progress made in establishing national standards for incident recording.

To assist the committee, I thought it may be helpful to offer further clarity in these areas.

With regard to the action plans, an all-Wales template is in place for all Trusts and LHBs. During the Audit Committee David Francis explained the work that has been undertaken to develop action plans for each health community. These action plans intend to result in a step change in the actions taken by health bodies in tackling violence and aggression against staff. The agreed generic action plan template is attached as Appendix 1 as I thought the Committee would like to see what these plans actually looked like. The template sets out the target dates for delivery against each action and some health communities will deliver in advance of these milestones. There is a requirement that, by 1st October 2009, all *new* LHBs will be operating to a single plan. In the meantime, some health communities have opted for a composite plan, namely, Cwm Taf, Hywel Dda and the whole of North Wales, whilst in other parts of Wales the Trusts and LHBs are currently following separate plans.

This duality of approach reflects local circumstances. All LHBs and Trusts, including Welsh Ambulance Trust, are covered by a local action plan.

An example of a local plan is attached as Appendix 2. Timescales are included in all plans and progress against plans can, and will, be carefully monitored. There is a requirement that progress against the plan is reported regularly to Boards and, thus, this information will be in the public arena. There will likely be need to revisit some areas of the generic plan in coming months, but this will be done as part of the National Steering Group's work.

With regard to availability of data regarding proportion of NHS staff trained under the Passport Scheme, all Trusts in Wales currently provide training to staff in line with the All Wales Violence and Aggression Training Passport and Information Scheme. All Trusts had in place mechanisms for monitoring the amount of staff trained as a percentage of those staff requiring training identified through a training needs analysis. Since the recent restructure of NHS Trusts, not all are able to supply this information as they are merging their training records. Trusts have given assurances that this information will be available again when the new LHBs take effect in October 2009.

With regard to progress made in establishing national standards for incident recording - All trusts record incidents of violence and aggression and report that information to WAG. All Trusts currently use a risk management system for recording all incidents, claims and complaints (Datix). As I mentioned at the Audit Committee, Trusts are currently using different versions of Datix and by October 2009 they will all have updated their current systems to the most up to date version of Datix. This will allow Trusts to have the ability to report incidents electronically via their intranet systems and standardise the report form used making it specific for violence and aggression.
WAG officials have also developed standard recording codes for violence and aggression to allow consistent data capture which will allow better intelligence of the problem and ability to benchmark between Trusts. All Trusts have signed up to using these new codes although several are experiencing difficulty amending their Datix software due to merging data following reorganisation. Those Trusts affected have committed to ensuring these new codes are in place no later that 1st October 2009. Below is a chart detailing which Trusts are currently using these codes:

Trust	**New Codes in use**	**Action required**
Abertawe and Bro Morgannwg NHS Trust	Yes	
Cardiff & Vale NHS Trust		By Oct 2009
Cwm Taf NHS Trust		By Oct 2009
Gwent NHS Trust	Yes	
Hywel Dda NHS Trust		By Oct 2009
North Wales NHS Trust	Yes in part	Remaining areas by Oct 2009

Trust	New Codes in use	Action required
North West Wales NHS Trust		By Oct 2009
Powys	Yes	
Velindre NHS Trust		By May 2009
Welsh Ambulance Service NHS Trust	Yes	

WAG is currently exploring with Health Solutions Wales how data can be automatically shared by Trusts to a central depository from their Datix Systems.

Finally, I agreed to provide a note for the Audit Committee on the number of security staff employed within NHS Wales. I have attached as Appendix 3 a summary of this information.

I hope this written evidence helps provide further clarify to the Committee.

Yours sincerely

Mr Paul Williams
Director General, Department for Health & Social Services
Chief Executive, NHS Wales
Cyfarwyddwr Cyffredinol, Adran Iechyd a Gofal Cymdeithasol
Prif Weithredwr, GIG Cymru

Appendix 1 – NHS Trust/LHB Employers Action Plan

Violence and Aggression						
Employers Action Plan						
SPECIFIC ACTIONS	**RESPONSIBLE PERSON**	**TIMESCALE**	**X-REF TO RECOMM'NS**	**X-REF TO EXISTING NETWORK/ STANDING GROUP WORK**	**COMMENTS/NARRATIVE**	**COMPLETION DATE**
1. [As a "health community" (anticipating 2009/10 NHS Wales re-structuring)] Put in place a detailed action plan to deliver the recommendations of the V&A Ministerial Taskforce, as agreed with the Minister's		[not later than 31/01/09]				

nominated lead.						
2. Appoint a director who sits at the board with day to day responsibility for delivering on V&A action plan.		[31/10/08]	Reporting 11			
3. Ensure active involvement of executive director lead in work of the V&A National Steering Group.		[Ongoing]				
4. Establish appropriate structures at corporate and operational levels to ensure delivery of the action plan (see point		[not later than 31/12/08]				

18).						
5. Agree [Trust/LHB/2009+] Board policy of receiving quarterly detailed update reports on progress against V&A action plan.		[not later than 31/3/09]	Reporting 9			
6. V&A against staff to be made standing agenda item in formal scheduled Employer/Staff Side representative meetings.		[not later than 31/3/09 and ongoing]	Reporting 9			
7. Nominate Non Executive Director with specific focus on V&A against staff.		[not later than 31/3/09]				

8. Have in place an action plan to ensure full and ongoing compliance with requirements of the All Wales V&A Passport Scheme. (A review of the scheme will be commissioned)		[not later than 31/12/09]	Reporting 1-6			
9. Adopt and maintain All Wales common classification for V&A incidents.		[not later than 1/10/09]	Reporting 10			
10. All managers to have been trained, (to a level commensurate with their role/responsibility), in the effective recording and management of all incidents of V&A, and in the support and management of		[not later than 31/12/09]	Reporting 13			

victims**.**						
11. Linked to 10 above, annual performance appraisal of all managers to include measure of their effectiveness at managing V&A incidents .		[not later than 31/12/09]	Reporting 13			
12. All existing and future staff to have access to guidance on the importance of reporting all incidents of V&A**.** Each employer should be made aware of the importance of reporting all violent incidents.		[not later than 31/7/09 and ongoing]	Reporting 12 & 13			

13. Have in place processes/procedures that ensure timely (within 7 days) and accurate recording and analysis of all reported V&A incidents, and timely submission of agreed minimum data set to WAG in line with the national V&A action plan.		[31/12/08 and ongoing]	Reporting 13,14,16		
14. To implement all - Wales guidelines on early incident case management.		[not later than 31/7/09]	Reporting 12 - 16		

15. Pending publication of detailed case management guidelines (see 17 above) put in place interim procedures that ensure all reported V&A incidents are monitored on a daily basis, earliest contact is made with all victims (at the very latest within 3 days of incident), and an appropriate individual case management plan is put in place**.**		[Immediately and ongoing]	Reporting 12 - 16			
16. Victims to be offered access to appropriate psychological intervention without		[not later than 31/1/09 and ongoing]	Support 1 - 3			

delay ie. No later than 3 days post incident						
17. Where referral to occupational health is necessary, access is to be expediated on an "urgent" basis by the manager. The recommendations of the occupational health team must be delivered swiftly and monitored.		[not later than 31/1/09 and ongoing]	Support 1 - 3			
18. Pending (i) publication of high level Memoranda of Understanding between WAG, Crown Prosecution Service and Welsh Police Chief Officers (ii) appointment of case manager and (iii)		[not later than 31/12/08]	Prosecution [ ]			

publication of case management guidelines, Single Point of Contact (SPOC) to be appointed who will act as liaison with victims, police and CPS in respect of investigation and prosecution of specific crime related V&A incidents**.**					
19. Where an agreed A&E/Ambulance CCTV pilot site project exists, to fully co-operate with WAG and other agencies in implementing and assessing that pilot project. Knowledge of a person's violent		[Ongoing]	Prosecution 6 & 7		

conduct should be passed on to the A and E Department.						
20. Review and update existing risk assessments relating to V&A against staff and ensure effective ongoing review arrangements.		[not later than 30/4/09 and ongoing]	Prosecution 8			
21. Formal representations to be made to respective Community Safety partnerships (CSP) to ensure that V&A against NHS Staff is included as a specific action set within the CSP crime & anti-social behaviour		[not later than 31/3/09 and ongoing]	General 8			

action plan.						
22. Through active membership of the All Wales Network of Communications Officers contribute to the development of an All Wales V&A communication strategy and action plan**.**		[immediate and ongoing]	General 2			
23. Develop a communication strategy and action plan to ensure delivery of locally based obligations arising from ( ) above.		[not later than 28/2/09 and ongoing]	General 2 & 3			

24. Through the active membership of the nominated executive director lead, to corporately commit to supporting the work of the V&A National Steering Group, and other established All Wales Networks/standing groups that undertake development or oversight work on behalf of the National Steering Group.		[ongoing]				
25. From 1st January 2009, ensure earliest notification to Welsh Heath Estates (WHE) in respect of proposed new builds and/or any proposed		[immediate and ongoing]	General 6 & 7			

refurbishments (other than minor works), so that WHE in partnership with the Police in Wales can maximise the benefits of incorporating the principles of “Secure by Design**”.**						
26. Trusts should review their current risk assessments for all lone workers and ensure all reasonable steps are being taken whilst awaiting the WAG decision on funding for an all Wales system. Trusts to provide WAG with evidence of this review and highlight areas of best practice.		[immediate and ongoing]				

Appendix 2

Gwent Healthcare NHS Trust

Violence and Aggression

Employers Action Plan

SPECIFIC ACTIONS	RESPONSIBLE PERSON	TIMESCALE	X-REF TO RECOMM'NS	X-REF TO EXISTING NETWORK/STANDING GROUP WORK	COMMENTS/NARRATIVE	COMPLETION DATE
1. [As a "health community" (anticipating 2009/10 NHS Wales re-structuring)] Put in place a detailed action plan to deliver the recommendations of the V&A Ministerial Taskforce, as agreed with the Minister's nominated lead.		[not later than 31/01/09]			The Trust has established a V & A Steering Group to address the issues in the Ministerial action plan	Dec '08
2. Appoint a director who sits at the board with day to day responsibility for delivering on V&A action plan.		[31/10/08]	Reporting 11		Tracy Myhill, HR Director has been nominated lead Director	Complete
3. Ensure active involvement of executive director lead in work of the V&A National Steering Group.		[Ongoing]			Tracy Myhill, HR Director representative at V & A Steering Group	Complete

4. Establish appropriate structures at corporate and operational levels to ensure delivery of the action plan (see point 18).		[not later than 31/12/08]			Action plan monitored via the Trust Trade Union Partnership Forum, Steering Group and H & S Committee	Complete
5. Agree [Trust/LHB/2009+] Board policy of receiving quarterly detailed update reports on progress against V&A action plan.		[not later than 31/3/09]	Reporting 9		Action plan monitored via the Trust Trade Union Partnership Forum. First Board report planned for May 2009	On Going
6. V&A against staff to be made standing agenda item in formal scheduled Employer/Staff Side representative meetings.		[not later than 31/3/09 and ongoing]	Reporting 9		Actioned standard item at the Trust Trade Union Partnership Forum	Complete
7. Nominate Non Executive Director with specific focus on V&A against staff.		[not later than 31/3/09]			Phillip Champness agreed as Non Executive Director and in place	Complete
8. Have in place an action plan to ensure full and ongoing compliance with requirements of the All Wales V&A Passport Scheme. (A review of the scheme will be commissioned)		[not later than 31/12/09]	Reporting 1-6		The Trust was fully compliant with the implementation of the passport , although some of this is due for updating. An action plan is being developed to ensure full compliance on an on going basis.	On Going
9. Adopt and maintain All Wales common classification for V&A incidents.		[not later than 1/10/09]	Reporting 10		Common classification has been adopted.	Complete

10. All managers to have been trained, (to a level commensurate with their role/responsibility), in the effective recording and management of all incidents of V&A, and in the support and management of victims**.**		[not later than 31/12/09]	Reporting 13		Violence & Aggression identified as serious incident in Trust's Serious Incident Policy. Managers have access to the Serious Incident Policy via the Trust Intranet. Training plan currently being developed on V & A action plan and managers responsibilities. Incident reporting included in all H & A statutory training.	On Going
11. Linked to 10 above, annual performance appraisal of all managers to include measure of their effectiveness at managing V&A incidents .		[not later than 31/12/09]	Reporting 13		V & A included in appraisals carried out to KSF outline and covered by core H & S dimension, Evidence asked for to demonstrate how managers have dealt with any incidents.	On Going
12. All existing and future staff to have access to guidance on the importance of reporting all incidents of V&A**.** Each employer should be made aware of the importance of reporting all violent incidents.		[not later than 31/7/09 and ongoing]	Reporting 12 & 13		This is included in Health & Safety training which is mandatory for all staff and included in Corporate Induction. Working with the Trust Communication lead to roll out PR plan	On Going

13. Have in place processes/procedures that ensure timely (within 7 days) and accurate recording and analysis of all reported V&A incidents, and timely submission of agreed minimum data set to WAG in line with the national V&A action plan.		[31/12/08 and ongoing]	Reporting 13,14,16		This is currently not achievable within 7 days using the current datix reporting system, but will be if the business case for datix web is supported and implemented. Business case being finalised and will be presented to FET on 11 May 2009.	On Going
14. To implement all - Wales guidelines on early incident case management.		[not later than 31/7/09]	Reporting 12 - 16		Awaiting final guidance	On Going
15. Pending publication of detailed case management guidelines (see 17 above) put in place interim procedures that ensure all reported V&A incidents are monitored on a daily basis, earliest contact is made with all victims (at the very latest within 3 days of incident), and an appropriate individual case management plan is put in place**.**		[Immediately and ongoing]	Reporting 12 - 16		Personal Safety Office currently reviews all incident forms and follow up on all serious incidents with line managers to ensure effectively managed. Line managers currently support individuals and liaise with H & S.	On Going
16. Victims to be offered access to appropriate psychological intervention without delay i.e.. No later than 3 days post incident		[not later than 31/1/09 and ongoing]	Support 1 - 3		Support and Well Being services available to staff where appropriate. All referrals can access Occupational Health	On Going

					within 72 hours.	
17. Where referral to occupational health is necessary, access is to be expediated on an "urgent" basis by the manager. The recommendations of the occupational health team must be delivered swiftly and monitored.		[not later than 31/1/09 and ongoing]	Support 1 - 3		Facility available to fast track staff where appropriate	On Going
18. Pending (i) publication of high level Memoranda of Understanding between WAG, Crown Prosecution Service and Welsh Police Chief Officers (ii) appointment of case manager and (iii) publication of case management guidelines, Single Point of Contact (SPOC) to be appointed who will act as liaison with victims, police and CPS in respect of investigation and prosecution of specific crime related V&A incidents**.**		[not later than 31/12/08]	Prosecution [ ]		Health and Safety Manager will act as single point of contact and will be the nominated lead for single point of access	On Going

19. Where an agreed A&E/Ambulance CCTV pilot site project exists, to fully co-operate with WAG and other agencies in implementing and assessing that pilot project. Knowledge of a person's violent conduct should be passed on to the A and E Department.		[Ongoing]	Prosecution 6 & 7		When a CCTV system is installed in RGH A&E Security Control Room staff will record and collate incidence of V&A not only electronically but also manually in a log book. All named/authorised personnel involved in the pilot will have the full co-operation of the Controllers and management. Site Survey of RGH A&E undertaken on 17/04/09 by Crime Prevention officer and Simon Trigg, National Police Lead	On Going
20. Review and update existing risk assessments relating to V&A against staff and ensure effective ongoing review arrangements.		[not later than 30/4/09 and ongoing]	Prosecution 8		This baseline work was completed and is now being reviewed via the H & S audit programme and Personal Safety Co-ordinator visits to local areas	On Going
21. Formal representations to be made to respective Community Safety partnerships (CSP) to ensure that V&A against NHS Staff is included as a specific action set within the		[not later than 31/3/09 and ongoing]	General 8		This work will be built into the Transition Workstream for Workforce and OD to ensure comprehensive engagement.	On Going

CSP crime & anti-social behaviour action plan.						
22. Through active membership of the All Wales Network of Communications Officers contribute to the development of an All Wales V&A communication strategy and action plan**.**		[immediate and ongoing]	General 2		Wendy Warren identified as the Communication lead. Violence & Aggression to be incorporated into Trust Communication plan including all stakeholders.	On Going
23. Develop a communication strategy and action plan to ensure delivery of locally based obligations arising from ( ) above.		[not later than 28/2/09 and ongoing]	General 2 & 3		Violence and Aggression Employers Action Plan included within the Trust Team Brief	On Going
24. Through the active membership of the nominated executive director lead, to corporately commit to supporting the work of the V&A National Steering Group, and other established All Wales Networks/standing groups that undertake development or oversight work on behalf of the National Steering Group.		[ongoing]			Tracy Myhill as Executive lead will support this work and ensure local mechanisms to support the national work.	On Going

25. From 1st January 2009, ensure earliest notification to Welsh Heath Estates (WHE) in respect of proposed new builds and/or any proposed refurbishments (other than minor works), so that WHE in partnership with the Police in Wales can maximise the benefits of incorporating the principles of "Secure by Design**".**		[immediate and ongoing]	General 6 & 7		A & E Royal Gwent Hospital plans have been sent to Welsh Health Estates	On Going
26. Trusts should review their current risk assessments for all lone workers and ensure all reasonable steps are being taken whilst awaiting the WAG decision on funding for an all Wales system. Trusts to provide WAG with evidence of this review and highlight areas of best practice.		[immediate and ongoing]			Current policy in place and appropriate to the lone worker requirements. Lone Worker Policy to be reviewed in light of V & A Action Plan in August 2009. Risk Assessments are reviewed as part of the local Trust H & S policy and site visits by the Personal Safety Manager	On Going

Appendix 3 – Number of Security Staff in NHS Wales

Hospital Site	Number of Security Guards
Morriston	10
Princess of Wales	15
NPT Hospital	5 (car parking as well)
Barry Hospital	N/A
Cardiff Royal infirmary	11
Rookwood Hospital	N/A
St Davids Hospital	5
UH Llandough	13
UHW	22
Whitchurch	12
Glan Clwyd Hospital	1
Prince Charles	5
St Tydfils	1

Royal Glamorgan	7
St Cadoc's Hospital	2
Royal Gwent & St Woolos	22
Withybush General	0
Prince Philip	2
West Wales	2
Wrexham Maelor	5
Holywell Cottage Hospital	
Holywell Hospital	
Deeside Hospital	
Dobshill	
Lluesty Hospital	
Ysbyty Gwynedd	0
Park Street Clinic	
Ynys-Y-Plant	
Bro Hafren	
Velindre cancer centre	4

Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Archwilio
The Audit Committee

Dydd Mercher, 25 Mawrth 2009
Wednesday, 25 March 2009

Cynnwys
Contents

Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir cyfieithiad Saesneg o gyfraniadau yn y Gymraeg.

These proceedings are reported in the language in which they were spoken in the committee. In addition, an English translation of Welsh speeches is included.

Aelodau Cynulliad yn bresennol
Assembly Members in attendance

Lorraine Barrett	Llafur Labour
Michael German	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Janice Gregory	Llafur Labour
Lesley Griffiths	Llafur Labour
Irene James	Llafur Labour
Bethan Jenkins	Plaid Cymru The Party of Wales
Huw Lewis	Llafur Labour
Jonathan Morgan	Ceidwadwyr Cymreig (Cadeirydd) Welsh Conservatives (Chair)
Nick Ramsay	Ceidwadwyr Cymreig Welsh Conservatives
Janet Ryder	Plaid Cymru The Party of Wales

Eraill yn bresennol
Others in attendance

Gillian Body	Swyddfa Archwilio Cymru Wales Audit Office
Jeremy Colman	Archwilydd Cyffredinol Cymru Auditor General for Wales
Tina Donnelly	Cyfarwyddwr, Coleg Brenhinol y Nyrsys, Cymru Director, Royal College of Nursing, Wales
Dave Galligan	Pennaeth Iechyd, Unsain Head of Health, Unison
Ian Gibson	Dirprwy Swyddog Cydymffurfiaeth, Swyddfa Gydymffurfiaeth y Cynulliad, Llywodraeth Cynulliad Cymru Deputy Compliance Officer, Assembly Compliance Office, Welsh Assembly Government
Dr Greg Graham	Cymdeithas Feddygol Prydain British Medical Association
Dr Richard Lewis	Ysgrifennydd Cymru, Cymdeithas Feddygol Prydain, Cymru Welsh Secretary, British Medical Association, Wales
Elaine Matthews	Swyddfa Archwilio Cymru Wales Audit Office
Lisa Turnbull	Cynghorydd Polisi, Coleg Brenhinol y Nyrsys Policy Adviser, Royal College of Nursing
David Wallace	Swyddog Proffesiynol, Coleg Brenhinol y Nyrsys Professional Officer, Royal College of Nursing
Chris Woolley	Prif Erlynydd y Goron De Cymru Chief Crown Prosecutor for South Wales
Barbara Wilding	Cymdeithas Prif Swyddogion yr Heddlu Cymru Association of Chief Police Officers Wales

Swyddogion Gwasanaeth Seneddol y Cynulliad yn bresennol
Assembly Parliamentary Service officials in attendance

John Grimes	Clerc Clerk
Abigail Phillips	Dirprwy Glerc Deputy Clerk

Dechreuodd y cyfarfod am 9.30 a.m.
The meeting began at 9.30 a.m.

Ymddiheuriadau a Dirprwyon
Apologies and Substitutions

[1] **Jonathan Morgan:** Good morning. I welcome Members to this meeting of the Audit Committee of the National Assembly for Wales, and I also welcome our guests. I remind you that you can speak in English or Welsh; headsets are available with the translation on channel 1, and amplification on channel 0 for the hard of hearing. I remind everyone to switch off mobile phones, BlackBerrys and pagers, as they interfere with the broadcasting equipment. If there is a fire alarm, please follow the advice of the ushers.

[2] We have not received any apologies for absence this morning, and therefore there are no substitutions.

9.31 a.m.

Trais ac Ymddygiad Ymosodol yn y GIG: Casglu Tystiolaeth
NHS Violence and Aggression: Evidence Gathering

[3] **Jonathan Morgan:** We move on to the next item on the agenda, which is the substantive item this morning. We are starting our work examining the issue of NHS violence and aggression. This is the first evidence-gathering session, and Members will remember that the Auditor General for Wales provided a report, on which we were briefed on 25 February. Members then decided to launch an inquiry into this important subject. I am delighted that we have representatives of the professional organisations here this morning, and we will later take evidence from the Crown Prosecution Service and the Association of Chief Police Officers.

[4] I welcome our witnesses, and ask them to give their names for the Record.

[5] **Mr Galligan:** I am David Galligan, head of health for Unison in Wales.

[6] **Dr Graham:** I am Dr Greg Graham, representing the British Medical Association.

[7] **Dr Lewis:** I am Dr Richard Lewis, the Welsh secretary of the BMA.

[8] **Ms Donnelly:** I am Tina Donnelly, director of the Royal College of Nursing in Wales.

[9] **Ms Turnbull:** I am Lisa Turnbull, policy adviser for the Royal College of Nursing in Wales.

[10] **Mr Wallace:** I am David Wallace, the RCN professional officer.

[11] **Jonathan Morgan:** Thank you. You are all very welcome this morning. We have a number of questions to get through, so we will make a start. My first questions are directed at Tina Donnelly, Richard Lewis and Dave Galligan. What do you see as the main causes of underreporting in your particular staff group? Are there any differences between staff groups? Is there almost a cultural acceptance within the NHS of violence and aggression towards staff?

[12] **Mr Galligan:** There was a significant degree of support for the attitude of cultural acceptance in the past. I would like to think that that is changing now. Underreporting has developed over a long period, and is almost a self-fulfilling prophecy. People do not believe that anything happens as a consequence of reporting, and so they stop reporting altogether. We have had evidence over a number of Wales Audit Office reports in recent years indicating that underreporting has not significantly improved. I would like to think that, in the last 12 months, a lot of work has been done to identify proper reporting mechanisms, with champions at a local level to help to support strategies that, frankly, were not previously effective.

[13] This is an issue for us as much as anyone else. We need to do more—certainly, my own organisation needs to do more—to encourage a reporting culture, without impacting on the negativity that comes from people saying that they made a report and nothing happened. The systems are changing now. The only concern that I have is whether, as a consequence of the current reorganisation, we may lose some of the impetus around the changed direction.

[14] **Dr Lewis:** I would echo David's comments. There has been an improvement in the cultural acknowledgement that violence and aggression and abuse of staff is unacceptable. However, the Wales Audit Office report demonstrates that there is still insufficient reporting. People do not wish to come forward, and there are a number of reasons for that. David has mentioned some of them. People do not feel that enough is being done when they go through the process of reporting an incident. The perpetrators of the offence are not taken to court and there is no outcome.

[15] Within the medical profession, there is also a sense of empathy with patients in that they can be in a predicament and are angry or abusive for a particular reason. The work of the taskforce and the audit report may not have considered sufficiently why people become angry or abusive. That is not to mitigate the fact that it is unacceptable for people to abuse medical staff and workers in the NHS in any way, but if you take a sick child to an accident and emergency department where you have to wait for an inordinate amount of time, I think that any one of us would get angry if we were very worried. More could be done to look at why individuals get upset and angry at healthcare workers.

[16] However, we have to have a zero-tolerance approach to these episodes when they occur. With regard to doctors, one doctor reported to us, after someone was violent towards them, that they felt that they had failed. There was a feeling of embarrassment and that it was their fault that someone was angry with them, which precluded them from wanting to report the incident.

[17] **Ms Donnelly:** I agree with most of what has been said. Having talked to our members about the reasons for underreporting, I concur that a relevant reason for not reporting an incident is if staff see that no action has been taken by the employers in the long term. Completing an incident form is also a long drawn-out process, which frequently has to be done at the end of a very busy shift. When you have been on the receiving end of violence and aggression and it has affected you psychologically, you are less likely to want to go through a drawn-out process of filling out an incident form. Furthermore, you are often domiciled in the same areas of the building as those where you treat your patients and there is therefore a fear of retribution. Nurses are often in receipt of violence and aggression in the accident and emergency department, but it is increasingly a problem throughout the secondary

care sector. It does not matter whether you are nursing on a medical or surgical ward, you are still subjected to it.

[18] For many of the reasons that Richard outlined, patients have a perception about the service to which they are entitled, and if they do not receive that service, the healthcare providers are at the front end and they will bear the brunt of the patient's dissatisfaction. From our point of view, there is an increased awareness among staff about zero tolerance to violence and aggression, but unfortunately they are often put off by the fact that no real action is taken against the perpetrators of that violence, by the fact that it is a long drawn-out process and that, at the end of the shift, you have to complete the relevant forms. Some of the action that could be taken on that relates to the security staff in an NHS environment. For example, if the security staff completed the forms and pushed that action forward, perhaps we would not see such a high level of underreporting.

[19] **Jonathan Morgan:** On that point, do you think that underreporting is more prevalent in the nursing profession than it is among doctors and those represented by the British Medical Association or the others who are also represented by Unison? Is there a difference in reporting between professional groups?

[20] **Ms Donnelly:** From the point of view of nursing, the college and we undertake biennial surveys across the UK, and Wales is included in those. Four years ago, four out of 10 nurses reported that they had been in receipt of violence and aggression in the workplace from patients. Last year, that figure was eight out of 10. The reasons for underreporting, outlined in that report, are the same as those that I have identified. So, there is an increase of violence and aggression towards the nursing profession because they are often the ones who are in the hospital 24 hours a day, seven days a week. Richard will speak on behalf of the medical staff, but, in accident and emergency departments, it is an accepted culture for patients to turn up and be violent and aggressive. Nurses are trained to deal with anxious parents, which is the example that Richard referred to. The problems are caused by those patients who habitually turn up under the influence of drugs and alcohol. Not enough is being done to ensure that nurses are safe when dealing with that type of patient. We could learn a lot from our mental health colleagues and from clinical psychologists involved in enabling people who are subjected to violence and aggression to deal with it in a different way. Nevertheless, we need to see action being taken against regular attendees at any department. We know who they are, but our members are telling us that, currently, the police will be called and that they will take the person off the site for about an hour and then bring them back. Unfortunately, if the person is still under the influence of alcohol and drugs, that does not address the violence.

9.40 a.m.

[21] **Jonathan Morgan:** In his report, the auditor general said that the issues that were identified three years ago remain. The Audit Committee concurred with that. Do you think that any progress is being made? The auditor general said that some improvements have been identified but, from a staffing perspective, do you see those improvements?

[22] **Mr Galligan:** You do not go from where we were to where we need to be overnight. A great deal of time has been lost, but, over the past 12 months, since the appointment of David Francis as the champion for the service, there is a clear indication that somebody is at least taking ownership of trying to manage the problem. The trusts and local health boards have all had to improve and, in some cases, start from scratch with new action plans on how they will manage the problem. It is certainly a progressive process; it is not going to happen overnight. When there is evidence and people can start to see something tangible happening, we will start to see the benefits. It is an awful thing to say, but, frankly, it will probably be another year before we see something more measurable. As I said earlier, I do not want to lose focus with the current organisational change either, with a raft of new senior managers

perhaps, which would mean losing some of the expertise that exists around championing the cause of tackling violence and aggression. David Francis's appointment has been excellent in that regard; I just hope that it continues to bear fruit. However, it is a progressive process and, off the top of my head, I would say it would take at least another year, although that may be a conservative estimate.

[23] **Janice Gregory:** I am thinking about the other actions that health communities need to take, and, again, my question is to Tina, Richard and Dave. Tina, you mentioned that where there are security staff perhaps they should fill out the forms. That seems to be a good idea. Perhaps you wish to expand on that, but do you, Richard or Dave have any other ideas about other actions that could be taken?

[24] **Ms Donnelly:** On the first question, the Royal College of Nursing would like to see a change in the law to make violence or aggression towards any member of the emergency services an automatic offence; the same sanctions should apply as those that would apply to anyone attacking a police officer. That is the first issue. That would act as a deterrent. The second issue, from where we sit, is that, as I have mentioned, security staff could be the key people in completing the reporting forms and following any subsequent action. We would also like to see the police reporting back to the NHS trusts what action had been taken on arrests or cautions that they may have made. It would also be helpful to staff to know the numbers of reported incidents being taken forward, because, at this point in time, nurses have little faith that anything will be taken forward, so they do not think that it is worth reporting incidents.

[25] The other action that I commented on earlier was the involvement of clinical psychologists who work with patients and staff alike, so that, if there are regular attendees who, for whatever reason, are violent and aggressive, behaviour-management issues are addressed. There is some good practice going on in the mental health unit in Cwm Taf, where teams of nurses and clinical psychologists are working together to identify the key issues that might engender someone's violence. It is more than just a case of trying to prevent it happening; it is about seeing the premonitory signs so that you know when to de-conflict that. That is vital. I know that that is part of the passport, but this is a step further in dealing with patients who are addicted to drugs and alcohol. That sort of thing is not happening generally, but it should be.

[26] **Dr Lewis:** I agree with all those points. We mentioned creating a culture in which it is easier to report, to fill in the forms, and so on. Not enough is being done on that. Although we have training for staff through the passport scheme and so on, we also need training to encourage people to report appropriately, and systems should be in place to support that and make it easy. It should be part of the culture, and it is not at the moment. The primary care violence and aggression scheme, which puts those individuals that Tina mentioned into a separate system of management, could perhaps be looked at more widely in secondary care. That might help to deal with some of the reasons why people are violent and aggressive in health situations: mental illness that has not been picked up, drug addiction, and so on.

[27] **Mr Galligan:** Unison has not yet confirmed a view on whether there needs to be separate legislation with regard to public service workers. We would certainly be happier if the existing legislation were applied consistently. Common assault is common assault; if I assault someone in the street on a Friday night, I would expect to be arrested. However, if I go into a casualty department and assault a member of staff, seemingly, I would not. Is it a question of more legislation or of a more consistent application of existing legislation?

[28] As for who should deal with security and reporting, the NHS does not even have its own internal security force. To a significant degree, it is contracted in. On Saturday afternoon, these people are security staff in Sainsbury's; on Saturday night, they are security staff in the

accident and emergency department. That is not necessarily a comparable environment. If we want to take ownership of the reporting mechanisms, we need to take ownership of the security personnel whom we employ. There was a recent incident in Swansea where contract security personnel were working as porters. It is bizarre, but it transpired that that was an arrangement that worked locally. We need to maintain control over our workforce in this regard, and, in that way, we can ensure consistent standards. As Tina said, you need someone to take responsibility for properly reporting the incident, rather than leaving it to the individual concerned, who may be traumatised, frustrated or fed up.

[29] **Janice Gregory:** My second question is on training, and Richard touched on that. We all understand your comments about staff wondering whether there is any point in reporting incidents if nothing happens. I want to press you about training. Is it adequate? Is there enough of it? Do the staff understand it? Does the line-management system in healthcare assist staff to train? In addition, does it support them when they take the decision to report an incident? Shall we start with Dave?

[30] **Mr Galligan:** The violence and aggression training passport is a standard model that has been operated in Wales since 2004. However, it has some way to go in being applicable to all staff, and, ultimately, all staff could come across incidents of violence. There needs to be an all-staff approach in that model, and that is not the case at present.

[31] There are consistent standards in that, when training is in operation, it is the same everywhere. Again, whether it is adequate is probably subjective. My colleagues down the table know more about this, but I believe that the passport was devised some time ago, and took years to roll out. Whether it needs to be revisited is open to question. I am not knowledgeable enough about the modules themselves. I know that a new module is being developed, but perhaps someone needs to revisit whether the existing modules are adequate. From my point of view, the passport has been around a long time, and the problem with such things is that either they fall into disuse, or people become too comfortable making assumptions about them.

9.50 a.m.

[32] **Dr Lewis:** The passport provides a baseline level of training, but I agree with David that we have not evaluated how effective the training has been in diffusing violent situations and also—again from the auditor general's report—it does not seem to have gone far enough to change the culture to encourage more people to report. If it was working well enough, more people would come forward and would find it easier to raise their concerns. Like the Royal College of Nursing, the British Medical Association also finds that there is a mismatch between the number of our members who report violence in the workplace and the number who actively get those incidents reported through the system. So, while it is a useful baseline, it needs further evaluation. It needs to be built upon in a number of aspects to enable people to deal effectively with those who are showing aggression and abusing people in the workplace, and also to enable them to change the culture to allow people to appreciate that it is not an acceptable part of their day-to-day work, so that they are encouraged to report it and to diminish it for everyone's benefit.

[33] **Ms Donnelly:** There is an additional component. I will paint a picture very quickly. If you are a nurse working with a patient who has been violent and aggressive towards you, you reflect back on that experience and consider what you could have done to prevent it. The passport goes a long way towards looking at the de-conflicting elements right at the beginning. However, once you have been the recipient of violence, insufficient support is given with regard to how you deal with subsequent cases. It affects you as a nurse in how you treat patients. It is not only one or two of our members who have said that; I have met several accident and emergency staff who have said that the memories of when they were subject to

violence and aggression are still very raw psychologically and there is little to no support in the longer term to prevent them from going into another scenario and wondering whether their action or anything from their perspective induced it. The training needs to be continued until that member of staff feels confident to deal with a patient on his or her own again. The difficulty is that we often find that those nurses are not being given that support, so they go off sick with stress-related illness. They are off for periods of three months, they are out of the service, and then they come back in for an occupational health review and are often put back in on shortened hours for a short time. However, the training element—and that is my point in relation to working with clinical psychologists—to look at the precursors and the premonitory signs that you experience from a patient or that the patient is demonstrating for those members of staff who have been affected is not sufficient.

[34] **Janet Ryder:** The auditor general's report points to the fact that the Welsh Assembly Government does not have a full picture of violence across the NHS and across the trusts. If you agree with that, can you pinpoint what you think might be missing in that picture and what would help you to gain the full picture?

[35] **Mr Galligan:** I keep going on about underreporting, but, in a way, verbal aggression is often more intimidating than physical aggression, with threats to get you outside. That often takes place in community settings where people know each other outside the workplace. People often feel intimidated by that. I do not know how you manage that. It is quite often not reported because the staff know the people concerned, they may live on the next street and—without wanting to stereotype—in some communities, everyone knows everyone else and threats to get people outside the workplace are common. It is very difficult to follow that up, because it is usually on a one-to-one basis. We have no reason to believe that members are telling us about something that did not happen, but how do you take action on that? That continues the feeling that the staff have that they are sometimes there to be set up—not by the service, but they feel unsupported in those instances because they are rarely in situations where they can provide evidence. It usually occurs in one-to-ones with patients. They could be in danger even outside the hospital, because people threaten to wait for them until the end of their shift. That is difficult to manage. People can become quite anxious at the end of a night or afternoon shift if they have been threatened with someone waiting for them outside.

[36] I have not had to face that, but I have come across people who have, and they bear those scars for a long time. Often, their fear will manifest itself in other actions on their part, for example, they will look to work in other areas and you then lose their expertise. Much of our discussion has been about hospital settings, but ambulance crews face this kind of aggression day in, day out. They are seen as prime targets, because they have drugs in their vehicles and, often, the rapid-response vehicles are single-manned. It can be intimidating to be sent to an incident on your own.

[37] **Janet Ryder:** So, it would be wrong to restrict action purely to accident and emergency departments?

[38] **Mr Galligan:** Gosh, yes. We often talk about accident and emergency departments because they are the biggest focus but, beyond that, primary care is of particular concern. Anyone working in community settings or lone-worker settings is faced with the same situations. Ambulance crews will tell you ad nauseam about the incidents that they have come across. However, there is now greater use of single-manned rapid-response vehicles, and the issue of lone workers increasingly needs to be addressed.

[39] **Jonathan Morgan:** Richard, has the primary care situation improved at all?

[40] **Dr Lewis:** Greg can say more about the particular primary care aspects, but there is a lack of data collection on incidents on the part of local health boards. While practices may

keep their own incident logs, there is no pooling of those data or any clear strategy, as far as I can see, to address this in primary care. However, I think that the fuller picture is more of the same. We need to encourage reporting by individuals and create that culture. Perhaps we should triangulate other studies, which all unions undertake with their staff, and look to see whether there is a mismatch.

[41] The auditor general talks about benchmarking organisations. That is a useful way to get a better picture, because what is happening in one area generally, on the reporting side and on the culture of organisations to encourage people to come forward, will help to give you an idea of what should happen in another area. Tina mentioned the issue of the police completing feedback on what happens to people throughout that process. All those aspects help to develop a picture of what is happening in Wales and what we are doing about it.

[42] **Ms Donnelly:** There is also an important point here for the leadership within organisations, on their accountability for staff health and safety. Everyone has a part to play in that, but how leaders of NHS establishments in a primary and secondary care environment communicate processes of reporting is vital, whether they are responsible for lone workers or for staff working in a team environment. I agree with Dave on the lone workers. When you are aware of high-risk areas, it is down to the NHS managers to ensure that they do not send lone workers to areas of high risk. They should be held accountable for that if they do.

[43] However, these things are not just down to the leaders of the NHS; they are also down to the public. I commented earlier on managing the expectations of the public, but they expect a high standard from the NHS. When people hear words such as ‘targets’ and ‘expect to be treated’ and they are not treated, it engenders a disappointment that makes them feel angry. So, the communication processes are vital when people turn up to be treated in primary and secondary care environments. If you turn up with a condition and you have entered the right gateway in the NHS to be treated for that condition, the expectations are that you should be treated according to established policies, procedures and targets. However, when you turn up inappropriately to areas where you are not supposed to be treated, you will delay the system, and that communication process is not sufficient in Wales.

10.00 a.m.

[44] We are constantly telling patients that they can be seen within 24 hours or four hours, but we all have a part to play—whether as politicians or as leaders in the NHS—in raising public awareness in Wales that there are different gateways to the NHS and that, if people want to circumvent them under the misapprehension that they will be treated earlier, they can expect delays or expect less severe cases to be pushed through. I am talking about primary as well as secondary care. From where I am sitting, I would be looking at the leadership of the NHS to make sure that they are reporting incidents, and that they know that they have a duty to follow up the incidents that have been reported and to feed back to their staff.

[45] I reiterate what I said about the police needing to make sure that they close the loop, too, because they do not. It is of immense disappointment to NHS staff who have gone through the process of reporting an incident that the police come and maybe talk to the individual or take the individual away, but then they bring that individual back and that seems to be the end of it. If the NHS staff make a second call to the police, the police will come along and say, ‘We have already dealt with that; it is two hours down the line and so they should be less violent’. However, they are not less violent; in fact, they are even worse. That is what staff are telling us. There is a need to close the loop and report those incidents. If the police get a second call from a professional in need, it should not be pooh-poohed as being not as relevant as the first call because they have already been out.

[46] **Janet Ryder:** Dr Lewis has mentioned benchmarking as a possible way forward on

raising awareness and knowledge on this. Could I have Tina and Dave's views on whether benchmarking could be a useful way forward and whether it can be made to work?

[47] **Ms Donnelly:** I think that benchmarking implies that you are going to have standards and, where you have standards, people will try to achieve them. The issue with benchmarking is that one size does not fit all and, where you compare rural areas with inner-city areas, there is a higher incidence in different parts of those communities, so we would want to see benchmarks matched to those particular areas. There is no point expecting the same level of service from a minor injuries unit somewhere like the middle of Cardiff and somewhere like the middle of Powys. That is what I mean about benchmarking the perceptions of the care that you can give. So, I agree with benchmarking. David was seconded to the Welsh Assembly Government from the Royal College of Nursing for a year to look at this process. I do not know whether you can add to what I have said, David.

[48] **Mr Wallace:** I certainly agree with much of what has been said. On the cultural differences, the task group identified that there are geographical cultural differences in how things are reported and how they are perceived. There are also organisational cultural differences, in that verbal aggression has almost become the norm in an accident and emergency department and is accepted as part and parcel of everyday work; whereas, if you go to an elder care environment, it is not. So, there is a higher prevalence of reporting things like verbal aggression in long-stay units than there is in acute units, where they have to deal with the public. From interviewing many of the staff, we found that there were cultural differences between what was considered acceptable, and what was considered a verbal threat and verbal aggression. That level of acceptability might be different in the accident and emergency departments of the Prince Charles Hospital in the middle of the Gurnos, and in Cardiff and the Vale. For me, the issue is that we are approaching this very much from the perspective of what NHS staff can do, as though it is their problem, but it is a societal problem. We are missing the opportunity to get the public on board and to say, 'You have a responsibility' because it is the public that is actually undertaking the violence, not NHS staff. From the discussions that we have had this morning, we have looked at training, reporting or underreporting, cultural aspects and prosecution, but what I think is missing is public awareness and ways of educating the public.

[49] **Mr Galligan:** I would agree with the benchmark of like for like. It would be irrelevant to do it in any other way. It is not that long ago that we did not even use the same data for similar actions. It would be classified under one set of data in one location and classified differently somewhere else. There has been an improvement in that regard, but it has to be like for like, does it not? You could make comparisons between Cardiff, Swansea and Newport, I suppose, but, outside that, you would not necessarily be using the same features. It has a role, but let us ensure that the benchmarking is effective and that we are not just talking about it because it sounds nice.

[50] **Michael German:** On part 2 of the auditor general's report, many of you have already commented on the passport scheme and its shortcomings. However, I will pick up on two specific points that come out of your remarks. The first is about module D of the passport, which is currently missing. Tina has already talked about the good practice seen in psychiatry and other services. How significant is the fact that module D is not yet currently available to assist people with that fourth element of dealing with aggression? Perhaps Tina would like to answer first, and others can join in afterwards.

[51] **Ms Donnelly:** We have looked at the passport across the board, but I will defer to David because we seconded him to the Assembly Government to look at that particular area, and so he has first-hand experience.

[52] **Mr Wallace:** The answer to the question is that we just do not know, because the

data are not there to support it. We know what it is like from a feeling in our water, as it were, but we do not have empirical evidence to suggest that it is necessary to go to that length, because we have not seen the implementation of the other elements. A group exists that developed the passport, and it is reviewing it, but the passport will be only as good as the evidence that comes back to say how effective it is, and that evidence is not there. That is why the review period was put into the recommendations. The notion that people should get module D where a risk assessment notes that they are likely to be exposed to higher levels of violence is sound, but it is subject to a risk assessment.

[53] **Michael German:** Would anybody else like to comment on part 2?

[54] **Mr Galligan:** As yet, we do not have sufficient detail about how much work has been done. I am conscious that David Francis said that the area is controversial and that there is conflicting advice on it, but the extent to which it conflicts has not been shared with us as yet. I am not involved in the development of module D. It is described as 'restrictive physical intervention training'.

[55] **Michael German:** Yes.

[56] **Mr Galligan:** I can see why the language itself may be seen to be controversial. By implication, it means somebody physically intervening.

[57] **Michael German:** In the words of the Scottish system, whether you need that is 'not proven'. That is what I am sensing, but the case as to whether it might be needed is still open.

[58] **Dr Lewis:** In certain situations, such as secure mental health units, there will be requirements for restraint of some sort, and appropriate training will be required on using the right type of restraint to avoid the risk of injury to staff or patients. There is a need to review that, and there are several studies of various restraint techniques used in mental health institutions, some of them done by the RCN, to find the most appropriate and safe methods of restraining individuals who are violent through no fault of their own, but through illness. These methods allow for the individuals to be safely restrained and for staff to remain safe. There are selective areas where that needs to be looked at and the training appropriately implemented.

[59] **Michael German:** I wish to return to an issue that Janice Gregory raised, namely that of the passport training's accessibility. In your experience, are NHS managers, in general, allowing staff to take the right amount of time to undertake the training?

10.10 a.m.

[60] **Dr Lewis:** I think that the answer is 'no'. There is also the issue of primary care, where there has been insufficient roll-out of the passport scheme. I do not know whether Greg wants to mention it particularly.

[61] **Dr Graham:** Yes, it is simply that local health boards have not really taken this on board given the volume of people who merit the training. As with many things, they will put on a training exercise where a practice will release a few people to go, but they rarely follow it up—in fact, they never follow it up with enough training so that the entire practice team, over time, can go on such a training exercise. So, this needs to be spread much more across primary care.

[62] **Ms Donnelly:** In fairness to the acute care sector, the training is available but the issue is the release of staff. When we look at mandatory NHS training for other areas, about 56 per cent of mandatory training is done on things such as basic life support and infection

control. So, we must be cognisant of the fact that you can have the training, but unless you can release staff on the day, those staff will not access that training. The difficulty is that, when you take clinical staff out of the clinical area to do that training, you must backfill them and there is a cost implication in that regard. Whether you backfill them with agency or bank staff, there is a cost, and the difficulty is releasing them under the existing financial pressures. However, it should be made a priority, and we made a point of going to the annual general meetings of each of the NHS trusts and asking questions with regard to health and safety training and violence and aggression training. While how many people they train may be reported in some NHS trust annual reports, you need to make sure that those people have attended all the sessions and have not just attended the beginning before being called back to the clinical area. That is an issue.

[63] **Michael German:** Is there sufficient data on people completing the training?

[64] **Ms Donnelly:** No. When you ask directors of human resources for that information, you see that there is a willingness to provide the training. They might anticipate that they can release 500 staff a year to do the training, but you cannot get them released from the clinical area.

[65] **Michael German:** Turning to the issue of lone workers that you raised earlier, I want to look at the issue of knowing where they are using automatic tracking devices and whatever else. Some people find that quite invasive in their work, but there is no current Welsh system for knowing where lone workers are. Is that causing a major problem in primary care and for district nurses?

[66] **Ms Donnelly:** I suggest that you need to start in the areas of high risk and measure its effectiveness. We all work for organisations; if I were to look at my own organisation, I would see that we have an issue with lone workers but we have a system in place whereby we contact those people. It is down to management regarding how to link in with staff. I do not know of any organisation that does not have a lone-worker issue, and it is down to identifying which systems work effectively. I was in Powys last week looking at the new district nursing palmtop processes that they are piloting. It has almost immediate access to patients and going into homes, and you know exactly whether you are going into an area where previous members of staff may have experienced difficulties. It is that type of facility, whereby staff know that they are going to be accompanied by a second individual, whom they can arrange to meet in the vicinity, that should be put in place. That has been very effective in Powys; staff love it. It also gives instantaneous access to records, so there are issues with regard to that. Nevertheless, there is a variety of ways in which we could look at it, and pick out some of the most effective. The one that I am aware of is picked up from a different area to violence and aggression, but it has a knock-on effect.

[67] **Jonathan Morgan:** Bethan wanted to pursue this matter with her question, particularly on nursing services.

[68] **Bethan Jenkins:** You have touched on it. Is there enough support for lone workers? How could more support be provided? Are there instances of best practice in other countries that you have looked at that could be replicated in or adjusted for Wales?

[69] **Dr Lewis:** We have not specifically looked at issues like that, but there are systems that work through radio, for instance, in the ambulance service, where you have panic and alarm buttons for front-line ambulance service staff. I am not aware that that is used for district nurses or for community staff. It is about management: from a GP perspective, if you are visiting someone's home, someone should have some idea of where you are, but I am not aware of a well worked-out system. To pick up on Tina's point, we probably need to do more to look at high-risk areas, looking at what technology is available to assist home workers, but

I am not aware of any study or work.

[70] **Bethan Jenkins:** Is there any perceived differentiation between the rights of staff who go out to areas on their own and their rights in a hospital-type setting when it comes to reporting an incident? Do you find that that is the case at all or is it clear that they would still have the same support systems, which, granted, are minimal?

[71] **Ms Donnelly:** In the community, it is worse for the non-regulated healthcare workforce. When you go through a period of training, as a nurse does, you will have gone through how to deal with violent and aggressive patients. We are seeing healthcare support workers out in the community, as lone workers, without as much investment in their training and development. NVQ levels 2 and 3 look at the care component parts, without taking on the whole of the patient in the same way. Therefore, those particular healthcare workers are more vulnerable. So, the supervisory and support mechanisms that they have vary tremendously throughout Wales, which is again down to the availability of funding and how services are organised. In Gwent, there has recently been a change in the number of registered nurse practitioners looking after healthcare support workers. That increases not just the vulnerability of the patients in those areas, but the vulnerability of the workforce, because the range of their arm's-length supervision is even longer. The difficulty there is that, if you need to contact someone, the amount of people to whom you have to report, or report for directly, on a particular shift makes you vulnerable. It can also make your workforce vulnerable. Let us look at the high-risk areas, in which you have an increased number of staff reporting to fewer managers, because that increases the vulnerability, and see what systems and processes are in place to allow for that reporting mechanism.

[72] It is also about accessibility to patients in the community. Whether you have direct access or the right of access depends on your professional status, and even district nurses do not have the right of access into patients' homes. So, the safeguard there is that, if a patient refuses you for an aggressive reason, you do not see them that day, which can automatically be reported, but if you are in a patient's home and they suddenly become violent and aggressive, you must bring yourself out of that environment or deal with it. Those are the difficulties, and that is when the vulnerability of healthcare support workers, with relatively limited training, needs a stronger element of supervisory support. It is for those reasons.

[73] **Bethan Jenkins:** Does anyone else want to say anything?

[74] **Mr Galligan:** I agree with that, because there has been a significant increase in the number of healthcare support workers who are working in these settings, which, to be fair, is less expensive than having significant numbers of qualified staff. The ratio has changed and with that comes a risk. I doubt whether that risk has been evaluated in any way, but an increasing number of staff feel vulnerable when they have increased patient workloads. Mobile phones are not great for communicating in many parts of Wales, particularly in rural communities and we are excessively dependent on that technology, sometimes. People feel vulnerable, and they do not have access to the same in-depth managerial training that qualified staff would have in that regard. There is also a trend for healthcare support workers to work alone.

10.20 a.m.

[75] **Bethan Jenkins:** My question was on the environment.

[76] **Jonathan Morgan:** If you want to pursue that, that is fine. However, it was certainly mentioned in the discussion on the differences between the hospital and home setting. Are you happy with that answer?

[77] **Bethan Jenkins:** Yes.

[78] **Jonathan Morgan:** Huw Lewis has the next question.

[79] **Huw Lewis:** You have touched on the role of the police, and I wanted to pursue that a little further. The auditor general's report states that some trusts are unhappy with the response of the police, both its speed and, sometimes, its appropriateness. Does that resonate with you? Does it loom large on the radar? That question is to you all.

[80] **Jonathan Morgan:** Who would you like to answer first, Huw?

[81] **Huw Lewis:** It is becoming traditional to start with Dave.

[82] **Mr Galligan:** We have memoranda of understanding with the Crown Prosecution Service and the police. Perhaps I am too cynical in this regard, but the evidence suggests that a memorandum of understanding is just a memorandum; it is not working in reality. The reality is how people view the outcome, and their expectations. If the police are called, there is a genuine expectation that someone will take follow-up action, but as has been indicated several times, the police are frequently reluctant to take any action at all, for whatever reason. The police will attempt to defuse the situation, and to take the individual away, but that does not take away the group of people who may be supporting that individual. That is not always a successful conclusion, and where it is not successful, and the individual is arrested, we expect to see the CPS being more proactive. Again, experience suggests that the CPS is reluctant to prosecute, full stop. When it does prosecute, it is often on reduced charges. To give a fairly recent example—and I know that we should not take everything in the media as gospel—when an ambulance crew in Cardiff was attacked, the CPS reduced the level of the charges, and in the end they were fairly trivial. Expectations are damaged by that, and as I say, memoranda of understanding are great as long as they work in practice, and not just on a sheet of paper.

[83] **Dr Lewis:** I do not personally have any evidence other than the auditor general's report with regard to the speed of response. Anecdotally, within primary care, we always seem to have a quick response from the police to practice-initiated calls for assistance. If we are to bring about an entire change of culture, particularly given what colleagues have said about public perception and encouraging the public not to behave like this, we should have prompt police responses, prompt police action, and follow-through to prosecution and so on, where appropriate.

[84] **Ms Donnelly:** May I ask Lisa and David to comment on this for me?

[85] **Ms Turnbull:** This is an incredibly significant issue. Tina spoke earlier about everyone having a responsibility, and certainly there is a responsibility for local health organisations to improve and develop their relationships with the police locally. However, there is also a responsibility for the Welsh Assembly Government to take a lead on this. A general question was asked earlier about whether there is slower progress than there should be on some of the recommendations. This is certainly one area on which we think that there has been a lack of progress. The relationship between the police and the CPS needs to be tackled at a national level. We fundamentally feel that the prosecution rate should rise.

[86] You opened the discussion by looking at underreporting, and I think that every organisation here identified that one of the reasons for that was the perception that nothing will be done anyway. If the prosecution rate is shown to rise, that will encourage reporting, boost morale and improve confidence in the system. There are a number of recommendations in the taskforce report that would provide relatively simple solutions to this issue. One suggestion that I particularly wish to put forward is that we can learn from how England has

tackled the issue. The Department of Health in England led the way with its creation of the legal protection unit, which was specifically designed to raise prosecution rates. There is no reason why we could not follow that example here. However, we know that that has not filtered down to an operational level. As a professional officer, David has had first-hand experience of this issue.

[87] **Jonathan Morgan:** I do not think that we need to pursue this point at this moment, because we will be touching on the issue of the legal protection unit with the Crown Prosecution Service a little later. Huw, do you wish to come back on this?

[88] **Huw Lewis:** I have a specific point about something that the auditor general singled out. I am not suggesting that this is a cure for all ills, but it was highlighted as something that seemed to work, namely the presence of police in accident and emergency departments. Would you like to see that happen more? I see that there are lots of nodding heads. Thank you.

[89] **Lorraine Barrett:** We have touched on the memorandum of understanding, which has not yet been signed off. Do you think that a case worker in each trust to liaise with the police and the CPS will help to support affected staff and increase the possibility of successful prosecutions?

[90] **Ms Turnbull:** Yes, very much so. It is one of the key actions that we would like to see implemented. Again, it must be led at a national level.

[91] **Lorraine Barrett:** Dave, would you like to give the union's perspective on that?

[92] **Mr Galligan:** One point of contact would be excellent so that everyone knew the state of play. However, it is a resource, so there are cost implications. It would clearly be better for staff and, I would say, for the police, and it would be better for data collection to have one individual who has that responsibility.

[93] **Lorraine Barrett:** Looking at the resource issue, do you think that it would be more cost-effective to put money in at that end, thereby saving the cost of staff being off sick for three months or whatever? You would have a healthier, happier workforce. I see that you are all nodding again. [*Laughter*.]

[94] **Ms Donnelly:** It is one thing to have a caseworker, but the issue is how the work undertaken by the caseworker gets to the board—what clout it has. Thinking of where things have happened in the past, where there was a non-executive champion for infection control at board level, for example, it certainly kept the agenda live at that level. Having a non-executive champion in the new local health boards with the responsibility of ensuring that the caseworker reports come to the board monthly, and are then collated at Welsh Assembly Government level, would go a long way towards making this a key business area at local health board level.

[95] **Lorraine Barrett:** I think that that is an excellent recommendation that should go in our report.

[96] **Lesley Griffiths:** The auditor general's report found that staff were often unhappy with how security staff handled incidents. Do you think that this is still a problem, and, if so, what can be done? I was particularly interested in what Dave said earlier about the NHS taking ownership of security staff.

[97] **Mr Galligan:** My view is unchanged on that. If you have control of the staff, you can control their training and understanding of the NHS environment. I made the comparison with

Sainsbury's; it is a very different environment. I do not mean any disrespect to some of the security companies that are being contracted, but I do not think that they have the same empathy as other healthcare staff and healthcare professionals. I am not necessarily making a bid for in-house provision, but if we are serious about tackling violence and aggression, we must start by ensuring that everybody is on the same team. My impression from speaking to colleagues who have been directly affected is that not all the private security companies see their role in that way—that is the difference. If we had a consistent workforce, with consistent training standards and expectations, we would, hopefully, have consistent improvement.

10.30 a.m.

[98] **Dr Lewis:** I agree.

[99] **Ms Donnelly:** So do I. Dave has made a valid point. However, we would not want to see a situation similar to that in England whereby healthcare providers have to supplement the security system. This project was piloted in Liverpool. It causes a professional dilemma if one day you are acting as security personnel and the next you are a nurse in an accident and emergency department. It causes a dilemma regarding your professional code of conduct, especially if you have to go into a restraint situation. So, it would be about having staff that are unique to security systems, not pulling in people from other parts of the trust who are doing security work on a day off because they know how to do it. The project was piloted in Liverpool, and some success has been demonstrated there. However, as a professional body, we would say that nurses are on the live register 24 hours a day, seven days a week and, as such, if they have to use restraint, they are limited as to how much they can do, but if they are working as a security person, they can be held accountable for the elements of restraint used. So, the answer is 'yes', but they would have to be discrete security staff that are specific to the NHS.

[100] **Mr Wallace:** One of the points that came out of that is important. The evidence from the taskforce was that restraint is predominantly better if it is done by trained security staff, and there was a strong preference for a police presence. One of the riders around having security staff was that security was looked at from a violence and aggression perspective and that it was high enough on the organisational agenda that people were considered to be security personnel specifically, and were not asked to do a hotchpotch of jobs, which tend to be to do with car parking monitoring and the like. That needs to go. It needs to be specifically about security. Take away the car parking and the other add-ons. That was a sound point.

[101] **Lesley Griffiths:** Dave, you mentioned that you felt that the CPS was reluctant to prosecute. In cases where the CPS, for whatever reason, decides not to pursue a case, an individual can have a private prosecution. How good a fallback is that?

[102] **Mr Galligan:** Private prosecutions do not happen, do they? As I said, individuals may live in the same community as these people. On the responsibility and whether it is a failure on the part of the CPS to prosecute, I would like to see that responsibility adopted by the trust, provided there is sufficient prima facie evidence. In England—although I should not make comparisons with England—the Counter Fraud and Security Management Service has been effecting prosecutions to try to demonstrate the point, but that service does not operate in Wales on that basis. Perhaps we need to examine whether there are lessons to be learned from across the border—not that I am a big advocate of that.

[103] **Mr Wallace:** The committee may be aware that, as part of the recommendations from the ministerial taskforce, private prosecutions brought by individual members of staff who had been assaulted were to be supported where there was no support from the CPS. That is not happening. I have a case on my patch of a nurse who was assaulted and kicked unconscious. The staff on duty had pleaded with the police who attended to fine the

perpetrator with an on-the-spot fixed penalty, but the police declined to do that because it would prejudice the pursuit of any criminal prosecution. The CPS then declined to pursue the case, and the trust declined to support the individual in pursuing a private prosecution. She is unable to do that herself because of funding problems.

[104] **Jonathan Morgan:** Are there are any supplementary questions that have not been covered?

[105] **Nick Ramsay:** I want to go back to a point that was made earlier about changing the law to make it a specific offence to assault emergency services or accident and emergency staff. I sensed that there was a difference of opinion. Is there a general belief that, whatever the problems would be in implementing it, there should be a new law? Do you think that making it a specific offence to carry out such an assault would encourage reporting or remove the problem of underreporting?

[106] **Mr Galligan:** I may have indicated that there was a difference of opinion, but I think that I said that I was unconvinced that there was a case for a separate piece of legislation when, quite clearly, the current legislation is not being applied. We have heard examples of people clearly having been assaulted, but no action having been taken and nothing happens as a consequence.

[107] **Jonathan Morgan:** I think that the point that Nick is making is that, if NHS workers knew that there was a specific offence that related to their profession, it would give them the confidence and the courage to report it, simply because they knew that there was something in law that related to their particular position.

[108] **Mr Galligan:** They would need to see evidence that that was working in practice. If there are existing statutes regarding what constitutes an assault and what merits a criminal prosecution that are not being operated, if we simply badge it as an assault against a public service worker but we still do not operate it, people will not believe in it.

[109] **Janice Gregory:** I want to go back to David's earlier point. There was a sharp intake of breath when you cited the example of the nurse and told us what subsequently happened. I take your last point that it cannot be pursued for legal reasons. I am a trade unionist and I know that the unions that I belong to have legal services. As professional bodies, would you step in in such a case and support that individual, thus taking the trust or any healthcare setting out of it?

[110] **Ms Donnelly:** Yes, we have our own legal team and we would pursue that. However, to go back to the question that Nick raised, that is exactly why we are campaigning—and it is an RCN UK campaign—to make it an offence for anyone to attack a healthcare worker and to have the same sanctions as those that would apply in assaults against police officers. That would negate the onus to report an incident being placed on the individual recipient of that behaviour. That is why we are advocating it. Such an action would prevent cases where people are unable to pursue a course of action because of further actions that might be taken later and negate any subsequent action. That is exactly why we are pursuing the issue from the perspective of the royal college. We would like to see the same sanctions apply in cases where NHS workers are assaulted as would be the case were a police officer to be assaulted.

[111] **Jonathan Morgan:** Thank you. Are there any further supplementary questions? I see that there are not. Therefore, I thank our witnesses for coming in this morning; we are very grateful.

[112] I will move us on to the next evidence session. Two witnesses have joined us this morning. I ask you to identify yourself for the Record.

[113] **Mr Woolley:** I am Chris Woolley, the chief crown prosecutor for the Crown Prosecution Service, south Wales.

10.40 a.m.

[114] **Ms Wilding:** I am Barbara Wilding, chief constable of South Wales Police, but I am also appearing here as the chair of the Association of Chief Police Officers in Wales.

[115] **Jonathan Morgan:** You are both welcome. I am not sure whether you heard the evidence that we received earlier, but no doubt Members will refer to that when they turn to their questions. I will start with a question on reporting incidents. This was raised in the auditor general's report and was identified by the Audit Committee as an issue. It was referred to by Unison, the BMA and the RCN when they gave evidence this morning. Do the CPS and APCO Cymru have a view on how the level of reporting can be improved?

[116] **Mr Woolley:** Diolch am eich gwahoddiad heddiw. **Mr Woolley:** Thank you for your invite today.

[117] The CPS has identified that there is considerable reluctance among staff to report violence and that may be due to many factors, for example, a belief that nothing can be done, a consideration of the staff-patient relationship, particularly if mental health issues are involved, and an acceptance of harm as being part of the job. That is not a view shared by the criminal justice agencies. We regard assault on NHS staff as an aggravating feature and the courts, in applying sentencing guidelines, should increase the sentence to reflect that.

[118] We think that we have made a start in Wales. We have, as a CPS, agreed a memorandum of understanding with the Welsh Assembly Government that is now uniform throughout Wales, so staff, in whichever trust they work, can see what level of service they can expect from the CPS and Barbara will talk about the memorandum of understanding with the police.

[119] We have also improved our witness care units considerably since 2005, which again should encourage staff to report violence, if they know that they will be looked after throughout the criminal justice process. We can work with individual trusts to alert staff to what can be done for them if they report because I fear that, at the moment, there is a lot of ignorance and fear about the criminal justice system; staff do not want to enter it. If, for example, they knew that we could apply for special measures and conditions to protect them throughout the criminal justice process and that we would look after them as witnesses and victims in the system, I feel sure that they would be more ready to report.

[120] **Ms Wilding:** From a police perspective, I am somewhat disappointed in that focusing on getting people to report is only half the story. We should be preventing these assaults from happening in the first place. When the Minister established the committee to look at assaults in the health service, we were originally not included. I wrote to the Minister, saying that I felt that the committee needed a policing perspective. That was accepted, but, sadly, we were only invited to sit on the prosecutions side of the committee, despite having much to contribute with regard to the flow of patients going into accident and emergency departments, particularly alcohol-related cases. By working together and by sharing information, we can identify spots from which people tend to go to accident and emergency departments and we can work to reduce the alcohol abuse in that area; we have done that on many occasions. For example, polycarbonate glasses were issued over a four-week period before Christmas in Swansea and, as a result, we reduced the number of people being admitted to accident and emergency departments with wounds by 78, which was a saving of £9.3 million to the health service and to other partners; that was achieved simply by reducing that number by 78.

[121] At any one time, at least 35 per cent of admissions to accident and emergency departments are alcohol related. That goes up to 70 per cent on Monday, Tuesday and Wednesday nights, but for the nights during the rest of the week, it can go up to 100 per cent. Our point is that on those committees, we should have been working with the NHS to see how we could reduce those flows. We should then consider how we can respond to what happens when people arrive in the hospital. I do not take the view that we respond differently to assaults in NHS property, whether those are on people making domiciliary visits or on hospital staff. We treat every case equally importantly. Where we have looked for evidence to see where there might be a trend in us not proceeding, or not responding quickly to the NHS, we find no such evidence.

[122] My plea is that if any such evidence is presented before this committee, we as police forces would like to see it to make sure that our response is appropriate in accordance with that evidence. I have heard lots of anecdotes, but I do not see any evidence. Clearly, to encourage any community to respond—I look at the NHS as a community—you have to be able to demonstrate positively that you take it seriously. Again, I think that there is a lot of perception that things are not taken seriously, but also there is quite a high tolerance among staff. I see this in my staff: where people are confronted day in, day out by people who are perhaps not able to reason for themselves because of mental health issues or alcohol misuse, the staff have a high tolerance level and just see it as part of the job. They might moan about it afterwards, but they see it as part of the job and do not report it. It needs to be part of the NHS culture to be able to say, 'This will not be tolerated and we want to support you'. I think that a lot of that must come from within, but also from working with us so that we can demonstrate that we take positive action.

[123] **Jonathan Morgan:** Before I move on to Janice Gregory, on the issue of reporting—it is still a major concern of the professional bodies and it was certainly raised by Members—have you seen an increase in the number of cases reported by healthcare workers, whether primary care workers, lone workers working as district nurses, or those working in accident and emergency departments? Has there been an increase in the number of prosecutions?

[124] **Mr Woolley:** Anecdotally, there has been an increase—I did an audit before coming to give evidence today. We completed successfully two prosecutions in January for assault against NHS staff in the south Wales area. Currently, we have three cases ongoing from all parts of south Wales, which includes assaults on midwives, paramedics and assaults in hospitals. So, anecdotally, we have seen an increase. I did note the evidence given in the previous session that there was no feedback on how many prosecutions are going on and, it has to be said, we do not currently isolate this group of offences as a specific group. That is not to say that work could not be done by us, in partnership with the Welsh Assembly Government or the NHS trusts, to get better figures and I would welcome them into my organisation to look at that, to give the committee a better idea.

[125] **Ms Wilding:** We have had terrible difficulty in trying to isolate that group of people, because it is such a wide group, so I cannot tell you whether the calls have increased or not. In relation to the evidence that was presented earlier, I can tell you about hundreds of cases every week where the ambulance service calls us to premises where, from its indices and intelligence, it knows that there has been violence towards its members of staff previously. At the moment, we are looking to cleanse that data because it is somewhat out of date and we can update it. In a 10-day period, South Wales Police, on its own, attended over 400 cases with an ambulance because they knew there was likely to be violence at those premises. I do not see any other part of the NHS doing that. I listened to the evidence about care workers or health workers visiting homes. We have the same problem, but we have an intelligence database and it occurs to me that I do not know what intelligence database the NHS has. It certainly does not share it with us so that we could help to bring it up to date. I am not sure

whether the NHS, under health and safety, does dynamic risk assessments, which is certainly what our staff do. Before we send anybody to any premises, we do a dynamic risk assessment and decide whether it should be one officer, two officers or a van that will attend. If the NHS does have an intelligence database, it ought to be shared with us so that we can operate on one database. We respond to the ambulance service. It is a matter that we are discussing with the ambulance service because it is too much, but now that we know that, we can bring it down. I think that the health service needs to do more to help itself, frankly, but we are here and we will respond when we know that there is violence.

[126] **Janet Ryder:** I wanted to clarify the use of the word 'anecdotal' in relation to the cases that you are seeing. You are talking about cases that you say that you are prosecuting and yet you are calling them anecdotal. Why are they 'anecdotal'? Are they anecdotal because you have not separated out where they are coming from?

10.50 a.m.

[127] **Mr Woolley:** It is anecdotal, because we do not subdivide that as a class of all prosecutions. The cases are certainly not anecdotal, in that I can refer to real cases.

[128] **Janet Ryder:** So, there is no separation at all? In any of the facts or statistics that we could glean from you, is there is no separation between cases relating to everyday incidents of violence and those that occur in a medical setting?

[129] **Mr Woolley:** We class our cases by the category of offence. So we have the figures for grievous bodily harm, assault and, occasionally, actual bodily harm.

[130] **Ms Wilding:** The same is true for us. Home Office classification does not require us to note whether the incident occurred 'in a medical setting', as you put it.

[131] **Janice Gregory:** Comparing your evidence with that of our previous witnesses, I feel as though I am in a different meeting. Our previous witnesses, the healthcare professionals, were adamant that their staff are not getting the support that you, chief constable, suggest that they are.

[132] Chris, the CPS came in for a fair amount of criticism in that, if anything is reported, it does not go anywhere. I take your point about the two successful prosecutions in January and the three that are ongoing—we can all take heart from that. Out of how many is that? How many have been referred to the CPS on which no action has been taken? This is not my prepared question, as I think that you have answered that. I am heartened to hear that you do not think that it should be accepted that if you work in any type of public service—I think that that was the thrust of your comments—you can be a target for violence.

[133] Barbara, anecdotal or not, people told us in the first part of this session that the police may come out, they may act, and they may take the perpetrators away for an hour if they are suffering from the effects of alcohol or drug abuse and then bring them back—I do not know whether you heard that part of the evidence, but that is what the RCN told us. The perpetrators are brought back in no different a state to when they were taken away. If the police are then called back because there has been an act of violence, it is pooh-poohed. What worries me now is that, if the police are not aware of this, there are people somewhere who need to talk to each other, and this matter needs to come to the fore. That evidence will be a matter of record when the Record of Proceedings is published. You will see that the health professionals cite examples. Dave Wallace cited an example of, I think, a nurse who was beaten to the ground and left unconscious, and the CPS took no action.

[134] As a member of the Audit Committee, I am incredibly frustrated. I am heartened by

some of your comments, but incredibly frustrated to have had representatives of healthcare bodies here this morning who have been frank about what they have to see their staff suffer daily. Both of you then come here and, frankly, tell us that that is not the situation as you see it.

[135] **Ms Wilding:** I will answer first.

[136] To take someone away from casualty—I cannot talk about the specific case, because I do not know about it—who has caused a disturbance and then take him or her back beggars belief, frankly, unless it is somebody who requires medical treatment who had gone there as a patient, and our doctor has said, 'Take them to hospital'. Things are not always quite as they seem. It is difficult to respond when these specific cases are cited. However, there are two things. When I am out and about and I hear the calls, I know that we respond to accident and emergency departments in my force area. I hear us responding all the time. I often see the police helicopter over the hospitals, as well. So, from the evidence that I looked at before coming here, I know that we get frequent calls, we respond to them, and they are treated according to the nature of each individual incident, as you cannot give blanket treatment. Where we have a presence in the hospital, as we do at the Heath and at several other hospitals throughout Wales, it is a fact that staff reassurance and confidence improve dramatically, so it is well worth the investment for those hospitals that pay half and half for a police community support officer. Confidence grows and the quality of our intelligence improves, which means that we can identify demand points and allocate resources better. Each hospital is covered by a neighbourhood team, because the hospital is in the community. So, in the hospital setting, we definitely give a response, and, if any of the previous witnesses want to give me details, I would be quite willing to look into those cases and feed back to the committee the reasons for what happened. It will be easier to pick out individual cases as opposed to looking for examples from the mass of records.

[137] However, I understand the situation, which is why I said in my opening point about the police being represented on every aspect of that committee. We could have had a much greater meeting of minds than there has been through the committee that was set up.

[138] **Mr Woolley:** To echo Barbara's comment, if individual cases of concern have been reported, please let me know about them and I will follow them up. When any of my prosecutors are advising the police about any case, they look at two tests. First, they ask whether there is sufficient evidence to prosecute and secondly whether it is in the public interest to prosecute. Inevitably, it is in the public interest to prosecute the overwhelming majority of these offences, but that is not what we are concerned with; we are concerned with whether the evidence is there. We can go only on the evidence that is presented to us and the evidence that Barbara's officers have been able to glean. We will do our utmost to prosecute any offence in this setting if there is evidence of it. However, if there is not enough evidence, we would be acting against our public duty and responsibility if we were to authorise a prosecution to go ahead when we knew that it would fail. So, that is the test that my lawyers would apply.

[139] **Ms Wilding:** The memorandum of understanding states that if there is a single point of contact for reporting to police, it will make all this much easier. It also says that incidents of violence will be treated as a priority. That is in our statement and that is how we view this, which reflects the view of all police forces in Wales.

[140] **Jonathan Morgan:** Janice, do you want to come back on that?

[141] **Janice Gregory:** Of course we all understand what you say about the need for weighty evidence, Chris, but would that be the same if the violence was directed at a police officer, for example?

[142] **Mr Woolley:** Yes.

[143] **Janice Gregory:** So, there is absolutely no difference.

[144] **Mr Woolley:** No. In both cases, the officers concerned are serving the public. So, if they are assaulted in the course of their public duty, it is an aggravating feature common to both cases.

[145] **Lorraine Barrett:** I have probably watched *Casualty* for too many years on a Saturday night. [*Laughter*.] The example that I usually think of is your officers being called into an accident and emergency department because medical staff are having difficulty treating someone who is obviously injured—perhaps they are bleeding, they have a suspected broken ankle, or whatever—but who is aggressive, violent, out of control or whatever. Where do your officers stand in dealing with someone who is behaving in that way but who is obviously injured and in need of medical care? They have a responsibility to treat them, but if your officers take that person away or do something, are there any instances in which your officers have been prosecuted? I can see that they are in a very difficult position.

11.00 a.m.

[146] **Ms Wilding:** Yes, they are in a very difficult position. If someone is in hospital and requires medical treatment, there is no point in removing them, because, if we took them to the police station, the police doctor would just say that they need to be in hospitals for x-rays and all the rest of it. So, it is very difficult to do, but officers would have to restrain them for as long as they could. Often, they cannot be treated straight away, because the level of alcohol in their blood is such that it would be dangerous for the doctors to administer any form of drugs. So, our officers are tied up there, and, to be frank, it probably happens day in, day out that they cannot deal with such a person. In fact, some consultants in accident and emergency units have said to me that that is where they are spending their time. They are trying to get these people through the system, but they cannot, because they are drunk and so they cannot administer any medicine. However, my officers are tied up restraining them and ensuring that they do not assault the staff.

[147] **Lorraine Barrett:** I will turn to my prepared question. Do you have any views on the training provided to NHS staff to help them to deal with issues related to violence and aggression? This may come back to what you said earlier, Barbara, about how you should be involved from the beginning when all these things are being discussed.

[148] **Ms Wilding:** The passport idea is excellent, because we certainly give our staff training on how to protect themselves in such a situation. It is often about psychological as well as physical dominance. So, the training is an excellent idea if it is carried out, but it needs to be maintained. It should not be done once just and then that is it; our staff must regularly undergo this training. It comes under health and safety rules that they are able to dynamically assess whether they should go in or stay out of a situation, or whether they should call for help or for back-up resources. The passport is an excellent idea to help people to protect themselves, but it is only one element. Under health and safety law, an organisation is required to make a risk assessment of any situation that it is sending its staff into, and of whether there should be one or two officers. That does not just apply to medical staff. When I worked in London, I learned that some of the big dairies had to do exactly the same thing when sending their milkmen to some of the estates, because they would be assaulted and people would steal their money on payday or steal the milk. Anyone who is giving a public service and who puts themselves in certain situations should be taught how to carry out risk assessments as part of their training and how to protect themselves.

[149] **Lorraine Barrett:** Is there a part here for the Crown Prosecution Service to play? I will ask the question that I wanted to ask the previous witnesses. Could an NHS trust be prosecuted for failing in its duty of care if its staff were put in positions in which they were not trained to look after themselves?

[150] **Mr Woolley:** It is difficult to say whether a trust would be prosecuted, because I cannot think of an equivalent criminal offence at the moment, but there may well be cause for an action under civil liability.

[151] **Ms Wilding:** When one of our officers fell through a roof, it was exactly the same situation, and the Commissioner of Police of the Metropolis had to grip the rail at the Old Bailey for that.

[152] **Lorraine Barrett:** I have a quick question on closed-circuit television cameras in a hospital setting. Do you think that they are of a quality that is useful in prosecutions? Are they useful tools in bringing prosecutions forward?

[153] **Mr Woolley:** They are essential tools. The quality has improved beyond all recognition in recent years and such footage forms a central plank of most of our prosecutions, where it is available.

[154] **Ms Wilding:** As you are probably aware, a taskforce has been set up, which my retired deputy chief constable, David Francis, leads on behalf of the NHS. My assistant chief constable, Dave Morris, has also worked on putting that together. That taskforce has identified four hospitals in which it wants to run pilot schemes. It is about target-hardening the hospitals, ensuring that the footage is of a good quality, because, of the 17 hospitals that have CCTV, only three have cameras that are of a good enough quality to use their footage as evidence. So, it has identified four hospitals to target-harden, where it will put in police community support officers and raise the neighbourhood policing profile. Sadly, that seems to have stalled a bit, and not from a want on our side, but because the money has not been forthcoming to take those recommendations forward.

[155] **Jonathan Morgan:** I have a quick supplementary to ask before I bring Janet Ryder in. You said that three out of 17 hospitals have CCTV equipment that is capable of providing good-quality evidence to be used in a prosecution. It may be difficult to answer this question at this point, but do you have any examples of cases that have been pursued on behalf of a member of staff in which there was an attempt to use what was thought to be good CCTV evidence but which did not turn out to be and so the case simply could not proceed?

[156] **Mr Woolley:** I cannot think of any immediately, but, whatever the standard of the CCTV image, we will always look at it to see whether we can get anything out of it. It may be of poor quality, but there may be something of value.

[157] **Ms Wilding:** We send it to a laboratory to see whether it can be enhanced. However, what we are saying with regard to those 17 cameras is that they are probably old equipment, and so their images would be very fuzzy, but the new equipment is very good. I am sure that that is probably the situation.

[158] **Janet Ryder:** Lone workers are a major area of concern. You have already made some comments about ambulance trusts calling out the police when they know that they are sending their crews into areas where violence has been experienced previously. A number of the groups who came to give evidence earlier said that certain trusts provide their workers with palmtops, which give a history of the location into which their workers are going, and that that could be linked up to requests for support. What more can trusts and management do generally to support their lone workers? What more do they need to do to link up with you?

What needs to happen to link their systems to yours to ensure that that support is there for their workers?

[159] **Ms Wilding:** As I indicated, we are learning with the ambulance service that its database can be out of date, and we can bring it up to date. We are working through that now to ensure that we data-cleanse it. If there is a similar database in NHS trusts, that is great, but we do not know about it. We need to work with trusts to ensure that the data are kept up to date. They are required to do that anyway under the Data Protection Act 1998, but we need to work together on that. Once they have those data, they need to ensure that the organisations and their staff are doing dynamic health and safety risk assessments, so that staff know how to approach each premises and person. The resources must then be put in to deal with that. As I said with regard to the ambulance service, if there is someone who is mentally disturbed who is absolutely refusing to go to hospital, we will attend to help—of course we will. Again, we would attend if a lone worker was going into that situation, although I would suggest that people should not be lone workers in those circumstances. In London, at night, doctors have a driver who is almost like a minder and looks after them when they are out on calls. This is not new, but it may be the first time that the situation has been faced up to here in Wales. However, people going into those circumstances should not be lone workers, and, if the situation is that serious, they should be calling us anyway.

[160] **Janet Ryder:** If those databases do not currently exist, what is the capacity for trusts or health boards to link up with those of their local forces to categorise areas? A health worker can be called in to any area, so is there scope for developing a very wide database to begin with, of zoning areas, if you like?

[161] **Ms Wilding:** I think that it is well known that we are always willing to share our data. Sadly, the health service is the most reluctant service to share data with us. We have those databases and, if the NHS were to set up a database, we would be happy to work with it. We would share information on areas and people, because it is about keeping people safe and enabling them to deliver their service. We would not fund it, but, if the health service would fund such a database—and one may exist, but, if it does, I do not know about it—we would work with it, in the same way as we work with the ambulance service.

[162] **Janet Ryder:** In cases of repeated illness that might be linked closely to mental illness, you can see that it might not be in the patient's best interests for health workers to share such information with you. How do you square the circle of providing data protection for that individual while protecting the worker who has to go into that situation?

[163] **Ms Wilding:** There is a great deal of work going on nationally around sharing data. The Heath hospital has shared data from its accident and emergency department with us in very appropriate ways, which could be a blueprint for other hospitals. We are pushing for other hospitals to share information with us, because it identifies where people who cause the problems are brought in from—the premises, streets, estates or whatever. We all tend to be looking at the same people, the same families, in the same areas. So, it has been successfully done. The NHS gave direction on sharing information on knives, when people have come in with knife injuries, and that is happening now.

11.10 a.m.

[164] So, the barriers are being broken down, and there are a significant number of areas that are helping us to overcome these barriers. Anonymised information is also good. If we have had problems in a specific home, having responded, say, to a call from an ambulance taking a mental patient to hospital, our database will show that. I need to know from my responding officers whether that person has access to needles, what sort of drugs he or she may take, what the background is and how they protect themselves. So, we also need to know

those sorts of things. Sharing data in this area is vital to all of us, and there are programmes around that would help us do that without compromising anyone's confidentiality.

[165] **Janet Ryder:** On a different aspect of protecting workers, is there any way in which some sort of panic button or emergency call button could be sent out with lone workers? Is that being used sufficiently and effectively enough?

[166] **Ms Wilding:** My staff have access to that all the time, of course, through Airwave. We share Airwave with the other emergency services, but not with NHS people, as far as I am aware. They are out on their own and they get into violent situations, and there is a great deal of comparison and cross-over here, but I am not aware of, say, district or psychiatric nurses having access to that at all, I am afraid.

[167] **Jonathan Morgan:** So, paramedics working for the ambulance service would have access to that as part of the emergency services.

[168] **Ms Wilding:** As I understand it, they would.

[169] **Jonathan Morgan:** But not anybody else working in the NHS?

[170] **Janet Ryder:** So, a midwife would not.

[171] **Ms Wilding:** Not that I am aware of, no.

[172] **Lorraine Barrett:** Would that be practicable? Would the system allow them to have that sort of equipment with them?

[173] **Ms Wilding:** I negotiated for the Royal Society for the Protection of Animals to have Airwave, because when RSPCA staff work with us, we need to be able to talk to each other. I do not think that the RSPCA has access to the panic button, but our staff do, and the fire service and the ambulance service also have Airwave.

[174] **Irene James:** You have already referred to what I was going to ask. The auditor general's report said that some trusts were unhappy with the response of the police when they were called to incidents and that they were concerned that, in some cases, the police were not quick enough and that, in other cases, the response was inappropriate for the situation. Do you accept that that could sometimes be the case?

[175] **Ms Wilding:** It always could be the case, but one would want to look at the specifics, if that information is available, because there may be other explanations for why the action was carried out in that way. I am afraid that, every time I have two, three or four officers dealing with a violent patient in an accident and emergency department, they are not dealing with burglaries and other 999 calls, so delays occur, inevitably. We do not have a resource for every second of every minute of the day, sadly.

[176] **Irene James:** Your response relates to the next part of my question on the report's findings that the number of violent incidents decreased when a police officer was present, particularly in accident and emergency departments. Why are there not police officers in accident and emergency departments in hospitals?

[177] **Ms Wilding:** That is because we do not have the resources for it, but where 50 per cent is paid for a police community support officer, the duties are organised around that. From my experience of being out and about, all my staff seem to be in accident and emergency departments. Winkling them out of there seems to be a bit of an issue, and I am not quite sure why. They go in there with people, they go there to respond to things, they take people in

themselves, and, any Friday, Saturday or Sunday night—and Thursday night, now, as it has become the new Saturday night—if you look outside accident and emergency departments, you will always see either a police bike, a police car or someone there. As I said, for the controllers, winkling them out of there gets difficult. So, there is quite often a visual presence in accident and emergency departments, because they are working there—they are doing something, but they are not posted there.

[178] **Jonathan Morgan:** Chief constable, you have mentioned the contribution that is made by hospitals towards a PCSO; does that happen in all accident and emergency departments in Wales?

[179] **Ms Wilding:** No, it does not. The taskforce wants to increase that in these four hospitals. It is about looking at the target-hardening of the buildings and how you design out violence opportunities—blind corners and such things—increasing the reach of CCTV, looking at access controls and increasing the presence of neighbourhood policing teams and the police community support officers.

[180] **Lesley Griffiths:** Like Janice, I feel that I am in two different meetings. For example, the previous witness said that staff feel that it is okay for them to be assaulted in accident and emergency departments, but not on the street. However, you say that you do not deal with cases differently in NHS settings. The same witness said that the CPS is reluctant to prosecute, but you have said that you do your utmost to prosecute. What more can the NHS do to ensure that you get effective prosecutions? You have just mentioned police presence and CCTV, but, Chris, do you have any views on that?

[181] **Mr Woolley:** I have very many views. Encouragingly, over the last year, we have engaged with most of the NHS trusts in Wales over anti-social behaviour. As you said, we take this a stage back and we prevent these offences from occurring in the first place. I have a dedicated lawyer who does nothing but advise on anti-social behaviour. He has had very productive meetings—in fact, prosecutions have emerged from those meetings—in setting up appropriate measures for trusts to discourage anti-social behaviour. For example, with perpetrators, we have recommended anti-social behaviour order conditions that can be applied in a hospital setting or on NHS premises.

[182] On a UK level, we have had some success in cases where people have breached their ASBOs. There was one notorious case in which Emma Anthony received a sentence of three and a half years for relatively trivial breaches of an ASBO in relation to a hospital setting.

[183] **Ms Wilding:** I would like to add that the taskforce is meeting on 1 April for an away day. One thing that it will look at is cross-agency process mapping. This is an exercise that will take an incident of violence from within an accident and emergency department right the way through the departments and through the hospital. That will identify critical intervention points, areas of weakness and opportunities for improved processes across all agencies. The University of Glamorgan is facilitating this process mapping. So, once again, we are gaining knowledge of these things and considering what more we can do at all stages throughout the hospital. That is the focus of this. We are also looking to undertake a similar exercise in relation to the lone-worker scenario.

[184] **Bethan Jenkins:** Before I ask my question, I would like to follow up on what you said earlier, that the fact that people are going out to socialise on more evenings each week is causing disruption in hospitals. Do you have evidence that that is the main cause of the attacks, or are there causes that we need to discuss here today?

[185] **Ms Wilding:** The statistics speak for themselves. Alcohol-related admissions into accident and emergency departments on a normal day are 35 per cent; this increases on a

Thursday, Friday and Saturday night to between 70 and 100 per cent of admissions. There is lots of evidence to show that. The two areas that one needs to be concerned with are alcohol-related issues and mental health issues. That goes across not only the NHS but also my organisation in relation to assaults on staff. Consideration also needs to be given to the use of weapons in the domestic situation, particularly knives, as they are accessible in the kitchen. However, it is due to alcohol and mental health issues.

[186] **Bethan Jenkins:** I am sorry; I just wanted to clarify that.

[187] My next question is on the memorandum of understanding between the Assembly Government and the chief constables, which I understand has not been signed. Do you believe that it would go some way toward protecting staff more than at present?

11.20 a.m.

[188] **Ms Wilding:** I do not believe that any piece of paper can do that, but it does raise people's confidence when they see something in black and white that tells them what they are entitled to. I would say that we aspire to deliver that all the time, even without the MOU, but the MOU is important to show staff what they are entitled to, and the service that we will endeavour to give, along with the CPS. That includes this single point of contact to report violent incidents in the hospital to police.

[189] **Jonathan Morgan:** Before I bring in Chris Woolley, having a memorandum of understanding between senior officials in organisations, such as the chief executive of the NHS and the chief constable of South Wales Police, is all very well, but how do you ensure that the officers who attend accident and emergency departments following a report of violence also understand those expectations?

[190] **Ms Wilding:** What I have done, and what my colleagues in other forces will do, is to make one of the chief officers responsible for violence in the NHS. Their role is to ensure that the performance framework identifies each of these points. My force, and probably North Wales Police as well, can track everything from the call to the specific officer to the service to the individual. On customer satisfaction, we have that clear line of sight from the call right the way through. With that kind of performance framework, you can check that it is happening.

[191] **Mr Woolley:** To add to that, we have been working with a memorandum of understanding for some years now, and we are a much smaller organisation than the police, which makes it far easier to me to communicate to individual lawyers. They all know about the memorandum of understanding. As has been said, it is practice that we should be doing anyway, but the important thing is that it clarifies the service that NHS staff can expect from us, and along with the police memorandum of understanding, it forms a seamless process.

[192] **Jonathan Morgan:** Bethan, do you have anything else?

[193] **Bethan Jenkins:** No.

[194] **Michael German:** Could I ask, Barbara, when the memorandum will be signed? What is its current status, what is the cause of the delay, and when was it submitted to the Minister?

[195] **Ms Wilding:** I do not think that I can give you a specific date. It is currently with the legal team in the Welsh Assembly Government. It has been through our legal teams, and it rests with the Government. We hope that it will be completed by July. We are ready to sign.

[196] **Michael German:** When did you submit it to the Welsh Assembly Government?

[197] **Ms Wilding:** I am not sure that I have that information now. We do not know, I am afraid.

[198] **Michael German:** Perhaps you could indicate the area of difficulty that the Welsh Assembly Government has with your MOU.

[199] **Ms Wilding:** I do not know what it is. From our point of view, it is okay. I do not know what the Government's difficulty is at the moment, but we can find out.

[200] **Michael German:** That would be helpful.

[201] **Ms Wilding:** We will feed that back to the committee.

[202] **Nick Ramsay:** Do you consider that the placing of a case worker in each trust to liaise with the police and the CPS will help to support affected staff and increase the possibility of a successful prosecution?

[203] **Mr Woolley:** We do, indeed. It is a welcome move. At the moment, we are liaising chiefly with the victim or the witness, through our witness care unit, but having one objective centre to liaise with would be of enormous assistance. For instance, we often have to go back to the hospitals to ask for evidence—photographs, doctors' notes and so on. It is awkward to put those kind of requests through a witness, because they may not be in that department. Having someone in the trust who understands the whole process of prosecution and investigation will make it far easier for us to liaise with them, and should result in better prosecutions.

[204] **Nick Ramsay:** I will ask a question that I asked earlier to the union representatives, about the law in this regard. At the moment it is covered by the normal law on physical assault, which obviously applies to all areas and all workplaces. Is there a case for making it a specific offence to assault NHS workers or do you think that that would add an unnecessary complicated level?

[205] **Mr Woolley:** There may be a case for doing so. Indeed, we are pushing against an open door. It is already a specific offence to assault police constables. We now have the Emergency Workers (Obstruction) Act 2006, which makes assaulting someone who is acting in an emergency capacity—and this would cover paramedics—an aggravating feature for the point of sentence. There is also section 119 of the Criminal Justice and Immigration Act 2008, which has not yet been brought into force in either England or Wales. It will differ in those two countries because in Wales, the Assembly's Department for Health and Social Services will introduce it. However, when that is introduced, it will make creating a disturbance on NHS premises a specific offence; it will make it easier for those who create a disturbance to be removed.

[206] **Nick Ramsay:** When is that likely to come into force?

[207] **Mr Woolley:** I checked that yesterday. In England and Wales, only the guidance has been introduced. It is not likely to come into force before the middle of this year in England. As for Wales, that is in the hands of the Minister for Health and Social Services.

[208] **Ms Wilding:** Following on from that, it is in the chief constable's gift to accredit hospital security staff, provided that they are trained to a certain level. We can accredit them to intervene because there is legislation behind that, which is what we will pursue.

[209] **Huw Lewis:** This is primarily a question for Mr Woolley, which concerns some

comments from the professional associations that we met earlier. They seemed to be unanimous on their frustration about the rates of prosecution and the fact that they had to use their own resources, as professional organisations, to back members of staff on private prosecutions. They were willing to spend money on that. Do you see a lot of that?

[210] **Mr Woolley:** We have seen no private prosecutions in Wales or England. The system, covered in the memorandum of understanding, is that the matter will be referred to the CPS first and if we do not feel that there is a case to prosecute, we will advise no further action. The victim then has the right, supported by their organisations, to bring a private prosecution. However, there are issues with that because if we had considered the case carefully, and if, in the absence of any new evidence, nothing further could be put to a private prosecution, then we would possibly intervene and say, 'We did not think that there was enough evidence to prosecute and it would be an abuse to allow this to proceed.'. However, the right to have a private prosecution is enshrined in the memorandum of understanding.

[211] **Jonathan Morgan:** So you are not aware of any work that has been done by the legal protection unit from the Department of Health.

[212] **Mr Woolley:** No; nor had there been a private prosecution in Wales when I last checked.

[213] **Huw Lewis:** My last question is a catch-all question. Is there anything that has not yet been drawn out by our questions, which you feel could or should be done to prevent these violent incidents?

[214] **Mr Woolley:** An immediate action that would be of great use—and the CPS throughout Wales would be willing to support this—would be to tell staff what has been done. We should tell staff that there have been successful prosecutions and tell them the results for us in Wales. I have been to several hospitals to talk to accident and emergency staff; I have lectured ambulance staff and they are continually surprised to be told that, for example, compensation could be made payable to them personally—there is a huge level of ignorance about that and knowing that may encourage staff to come forward. Staff are very encouraged to hear that even if perpetrators have mental health problems, they can be prosecuted if what they did meets the requirements of the code, and a sentence can include an order not only to punish the perpetrator, but to protect the victim in the future. So, you can have bail conditions to protect them while things are in train. However, if, for example, we take up a prosecution under the Protection from Harassment Act 1997, we can issue a restraining order that will last after the sentence has been passed. It is essential that NHS staff understand that because I feel that they are hugely ignorant about these matters. We are very willing to allay their fears and to encourage them to come forward to report incidents. It is not a bleak picture because the services that we provide to victims and witnesses, throughout the criminal justice system, have improved beyond measure in the last 10 years.

11.30 a.m.

[215] There are special measures that we can apply for in court—we can have reporting restrictions and we can protect identities. We can do a lot more now for victims, as the process proceeds, to make it easier. One simple thing that I am always advocating is that NHS staff, doctors and nurses can be on a standby system to give evidence, so that they do not have to hang around the court all day or all week to give evidence. They can be on the end of a telephone and be called in to give evidence when they need to. Those are the sorts of practical things that we need to tell NHS staff.

[216] **Ms Wilding:** There are one or two points that I would like to add. Through the sentencing policy in the community payback scheme, we can now get people to be seen to be

undertaking their community sentence in the area where they have created the problem. One of the things that we would like to be doing with mental health problems is to look more at the wraparound services, not just for the individual, but for the family. On anything else that we could do to promote safety, the Association of Chief Police Officers Cymru has nominated a single point of contact and it would be very helpful if NHS Wales could do likewise. It would be helpful if WAG would endorse, or perhaps even commission, a high level study on the strategic and operational benefits to be gained from close collaboration between the police and NHS Wales. Liaison at a strategic level is currently narrow in focus, mainly on operational issues. There is a great deal of uncharted potential yet to be explored, for example, working closer on public health matters, developing a better integrated approach to an estate's requirements, including the collocation of resources, collaboration on the delivery of better joined-up services in the neighbourhood and community wellbeing, improving information sharing, as I said earlier, and a more holistic approach to supporting people with mental health issues, rather than each agency dealing with them in isolation. We need to work more closely together and overcome the fear of breaching confidentiality because it is only that, a fear; in reality, it can be managed.

[217] **Jonathan Morgan:** Finally, we will have supplementary questions from those Members who wish to come back in.

[218] **Janice Gregory:** Chris, I listened carefully to what you were saying about support from the CPS for staff who have taken the momentous step of reporting an incident when they get to court. Of course, they have to get to court first—they have to get past the criteria and fit in with the code. Of course, we all accept that, as I am sure that the code will not be changed to incorporate just NHS staff or, in fact, any public sector workers. When you say that there is a lack of evidence, is that about the way in which the complaint is submitted, for example, the language that is used or the interview procedure? Do you think that a single point of contact in a hospital, for example—a sort of caseworker—would increase the quality, for want of a better word, of the complaint?

[219] **Mr Woolley:** It would, yes. We look at the evidence as we get it and we do not care about the quality necessarily—quality on presentation that is. We certainly look at the integrity of the evidence. The fact that it may be a one-on-one situation should not affect us because we prosecute where there is just one prosecution witness. We do not require corroboration of these assaults, to use the old-fashioned term. We can just accept the word of the victim and prosecute. It is very hard to say without having specific examples. To answer your main point, a central point of contact would help because through that person we could get any necessary records and see if there was any closed-circuit television footage or any photographic evidence that had not been made available. This is very much a partnership approach between us and the police, as we progress and investigate, because we are continually advising which pieces of evidence we need to prosecute. Often, I am afraid, it may be that the individual victim is reluctant to come forward and give evidence. However, there are ways of getting around that because even if the victim is not willing to give evidence, if there is enough evidence beyond what the victim might offer, we can proceed, as with domestic violence.

[220] **Janice Gregory:** There is no doubt, is there, that if people working in the services see successful prosecutions—

[221] **Mr Woolley:** Yes.

[222] **Janice Gregory:** We know from rape cases that if the public sees successful prosecutions, it gives it confidence. As an Assembly Member, I am concerned that we raise public awareness and make people realise that it is not acceptable for staff to have to suffer this treatment in their daily working lives. They also need the confidence that what they say is

taken seriously.

[223] **Mr Woolley:** I entirely agree. The CPS will be very willing to co-operate with NHS trusts in producing posters and information, and in giving appropriately anonymised examples of successful prosecutions and the sentences that have been imposed.

[224] **Ms Wilding:** I would just add that, if you have this single point of contact case worker, it would enable the victim impact statement to be taken to show how the incident has affected the victim's working life and private life post event.

[225] **Bethan Jenkins:** I would like you to clarify a small matter. You said that you went to hospitals and provided examples of case studies. Is that part of the training that is already happening in the NHS, or is it separate to that training? If the latter, should the two come together?

[226] **Mr Woolley:** It has been separate until now, but the CPS would be willing to participate in that training, possibly by being present at a session. We are willing to go to NHS premises to give that information. Alternatively, we could give information that could be disseminated to staff.

[227] **Bethan Jenkins:** Is that a reason to revisit the current training passport, because this is not happening currently?

[228] **Mr Woolley:** We are not currently a partner in that. Anything we do in that regard is ad hoc, but we would welcome an approach to be a part of it.

[229] **Bethan Jenkins:** Right.

[230] **Jonathan Morgan:** That concludes this session. We will send you a transcript of the session in the next couple of days.

11.37 a.m.

Cynnig Trefniadol
Procedural Motion

[231] **Jonathan Morgan:** I move that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 10.37(vi).

[232] I see that the committee is in agreement.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11.37 a.m.
The public part of the meeting ended at 11.37 a.m.

Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Archwilio
The Audit Committee

Dydd Iau, 30 Ebrill 2009
Thursday, 30 April 2009

Cynnwys
Contents

Aelodau Cynulliad yn bresennol
Assembly Members in attendance

Lorraine Barrett	Llafur Labour
Michael German	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Janice Gregory	Llafur Labour
Lesley Griffiths	Llafur Labour
Irene James	Llafur Labour
Bethan Jenkins	Plaid Cymru The Party of Wales
Jonathan Morgan	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Chair of the Committee)
Nick Ramsay	Ceidwadwyr Cymreig Welsh Conservatives
Janet Ryder	Plaid Cymru The Party of Wales

Eraill yn bresennol
Others in attendance

Gillian Body	Swyddfa Archwilio Cymru Wales Audit Office
Jeremy Colman	Archwilydd Cyffredinol Cymru Auditor General for Wales
David Francis	Hyrwyddwr Cymru gyfan ar gyfer mynd i'r afael â thrais ac ymddygiad ymosodol yn erbyn staff y GIG yng Nghymru All-Wales Champion against Violence and Aggression against NHS Wales staff
Ian Gibson	Dirprwy Bennaeth, Uned Llywodraethu Corfforaethol, Llywodraeth Cynulliad Cymru Deputy Head, Corporate Governance Unit, Welsh Assembly Government
Sheelagh Lloyd-Jones	Cyfarwyddwr Adnoddau Dynol, GIG Cymru Director of Human Resources, NHS Wales
Rob Powell	Swyddfa Archwilio Cymru Wales Audit Office
Paul Williams	Pennaeth, Adran Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cynulliad Cymru Head, Department of Health and Social Services, Welsh Assembly Government

Swyddogion Gwasanaeth Seneddol y Cynulliad yn bresennol
Assembly Parliamentary Service officials in attendance

John Grimes	Clerc Clerk
Abigail Phillips	Dirprwy Glerc Deputy Clerk

Dechreuodd y cyfarfod am 9.29 a.m.
The meeting began at 9.29 a.m.

Ymddiheuriadau a Dirprwyon
Apologies and Substitutions

[1] **Jonathan Morgan:** Good morning. I welcome Members to the National Assembly's Audit Committee. On housekeeping arrangements, I remind everybody that we operate bilingually, so participants are welcome to speak in Welsh or English. Headsets are available for translation and amplification.

[2] I remind Members to switch off mobile phones and BlackBerrys. If the fire alarm goes off, the ushers will instruct people on the best course of action to follow.

[3] We have received one apology for absence this morning from Janice Gregory, who is unwell. There are no other apologies or substitutions to note.

9.30 a.m.

Trais ac Ymddygiad Ymosodol yn y GIG: Swyddog Cyfrifyddu
NHS Violence and Aggression: Accounting Officer

[4] **Jonathan Morgan:** This is our second evidence and review session on the Auditor General for Wales's report on NHS violence and aggression. The committee will remember that it resolved on 25 February to launch an inquiry into violence and aggression within the NHS. On 25 March, the committee took evidence from the Royal College of Nursing, Unison, the Crown Prosecution Service, and the Association of Chief Police Officers. Today is the last planned evidence session for this inquiry.

[5] We have witnesses with us this morning, but, before asking them to provide an opening statement, I ask them to identify themselves for the record.

[6] **Mr Williams:** Good morning, Chair. I am Paul Williams, director-general for health and social services and chief executive of the NHS in Wales.

[7] **Ms Lloyd-Jones:** I am Sheelagh Lloyd-Jones, director of human resources for the NHS in Wales.

[8] **Mr Francis:** I am David Francis, chair of the Cardiff and Vale NHS Trust and the Minister's lead on the violence and aggression taskforce recommendations.

[9] **Jonathan Morgan:** Thank you very much. Before moving to the questions, is there any opening statement that you wish to make?

[10] **Mr Williams:** Yes, if I may. First, I am pleased to note that the Wales Audit Office report has noted an improvement in the management of violence and aggression in trusts in Wales. In 2007, the Minister for Health and Social Services announced the establishment of a ministerial taskforce to recommend a range of issues to improve the protection of NHS staff, and specifically to address three key elements related to violence and aggression: incident reporting, the prosecution of perpetrators, and support for the staff who are the victims.

[11] It is further encouraging to see that the Wales Audit Office has identified and recognised specifically the actions that were identified by the ministerial taskforce, and the work undertaken to bring these recommendations forward under the leadership of Mr David

Francis. I am delighted that David is with us here today to support me.

[12] In the wider context, the World Health Organization declared violence to be a leading worldwide health problem in 1996, but successive reports have failed to halt the growth of that global phenomenon. Healthcare workers who have face-to-face contact with the general public are considered to be at a particularly high risk of physical assault, with nurses at four times the national average risk.

[13] While the numbers of serious physical assaults across the NHS appear to be stabilising, the trend has continued to increase in the number of reported incidents. Although the numbers are clearly of concern, the increased reporting level enables NHS employers to understand the problems faced by staff and the issues that need to be addressed to combat the problem.

[14] In Wales, 7,800 incidents of violence and aggression were reported in 2007-08, and the incidents have apparently fallen in 2008-09 to just fewer than 6,950. However, I think that we have to treat those numbers with some caution because of reporting. From the data available, we see that the figures for Gwent indicate that 40 per cent of all incidents of violence and aggression resulted in injury to a member of staff. Some accident and emergency departments report that almost all violence and aggression was related to drugs or alcohol: it was 100 per cent in the North West Wales NHS Trust, 64 per cent in the Gwent Healthcare NHS Trust, and 69 per cent in the Hywel Dda NHS Trust.

[15] As you know, Chair, we are now moving to a major period of change. It is important that, during these significant changes, the management of violence and aggression continues to command the highest priority. You will have noted that, on 23 April, the Minister for Health and Social Services announced a number of new initiatives to help to protect NHS staff. They include a 12-month trial of closed-circuit television and developing services for lone workers. We have allocated resources to support both those initiatives, and the Minister has again stated that violence and aggression against staff is totally unacceptable and that she is determined to stamp out such behaviour.

[16] From my point of view, I am supportive of the work that the Wales Audit Office has done in the area. We have been able to demonstrate some progress, although further concerted action is required to achieve a major step change in the behaviours and attitudes of that section of our society who verbally abuse or physically assault healthcare workers. As the employer, NHS Wales must continue to minimise the risks, provide support and, when an assault occurs, see that the perpetrator is brought to justice.

[17] **Jonathan Morgan:** In paragraphs 1.1 to 1.5, the auditor general's report points to the fact that staff are reluctant to report all but the most serious offences. How do you intend to ensure that there is a change of culture among staff within the NHS so that they feel more comfortable and willing to report the offences as they occur?

[18] **Mr Williams:** That is an important issue. First and foremost, we need to improve awareness in general. The methods of reporting have not been easy, and so we can simplify the form—soon to be implemented. We are also offering web-based reporting to minimise the paperwork involved. We need to demonstrate some action on the ground by giving improved feedback on the results of reporting incidents, and by taking preventative measures. Investing in closed-circuit television, for instance, is an example of that. There is also the matter of the aftercare, and we may want to talk particularly about the role of the caseworker. Better analysis of information will also help us to deal with the root causes. I would underline the support of the employers at this point. Having a board champion regularly reporting to the board makes sure that staff are aware that the matter is at the top of the agenda. Those are the issues, but there are others. We hope to see an increase in convictions to demonstrate that we

are all terribly serious about this matter and that it is unacceptable.

[19] **Jonathan Morgan:** Moving on to a question for David Francis, in 2006, it was recommended that security staff take over the responsibility of incident reporting. Your Government says that that recommendation is being discharged. I wonder whether there has been any progress on that, as it was also suggested to us as a possible option in previous evidence. Should there be a change in where the responsibilities lie for reporting an incident?

[20] **Mr Francis:** Chair, there is no doubt that we can make some improvements in the training and the focus for security staff across Wales, but it is a bit of a complex mix at the moment in that some are employed within and some are contracted staff. There is some work to be done there.

[21] As for whether the reporting should be done by the security staff, I do not think that it is as simple as that. The key for success here is to ensure that line managers take responsibility alongside the member of staff. There will be occasions when security staff members could assist in the recording, although we may want to think that through a little more carefully. Their role would be better focused on being there and helping to manage the incident. I am not saying that it is not a role for them, but I would not want to absolve line management of the main responsibility. That is my suggestion.

[22] **Jonathan Morgan:** Okay, terrific. Thank you.

[23] **Michael German:** May I just look at paragraphs 1.6 to 1.12? The general picture is one of progress being made, but, in paragraph 1.12 in particular, we are given the impression that not all the health trusts have picked up on the new reporting system. We have also heard from the British Medical Association that there are no centrally collected figures for violence in primary care. Could you give us some indication of what progress is being made and of why it has taken so long to get everything in line so that we can get some robust figures and that we know what the situation is currently? Without knowing where we are, it is difficult to know how much action to take.

[24] **Mr Williams:** Maybe I could start, Chair. I have picked up on a pattern in the reports, which is that we do have patchy performance across Wales. The multitude of organisations that we have seen in the past has caused some difficulty in what I would call ‘universalising’ the best practice. Organisations had different definitions, different methods of collecting and analysing the data, and they have not always given us the priority that we would expect to be given. What we saw was that around 50 per cent of the organisations made progress or significant progress, and the others had a lot more to do.

9.40 a.m.

[25] We can talk about the progress that we have made, particularly since the recommendations of the report were considered by David Francis and his taskforce and we separated out what needed to be done by the employers. We now have employers’ action plans, and I am pleased to say that, when they were requested by David Francis, they were all submitted on time, in February. We are now going through those again.

[26] The new local health boards will be established in October, and 50 per cent of the new local health boards are already implementing this, with the others committed to implementing it by October. We will have seven boards, with each board having, for the first time, a workforce director as a main board member, a champion, and a performance management system. We can dwell on the past—and, as I said, the results are patchy—but there is now a robust system in place. We have the reinforcing comfort of a much more streamlined process and systems to ensure that we move forward significantly.

[27] **Michael German:** Is it therefore the position that, from October, there will be uniform reporting? Will the figures that come in be robust for the whole of Wales, rather than parts of Wales and for secondary care only? If so, it would be good to acknowledge it, but what is the position in respect of primary care?

[28] **Mr Williams:** I will ask Sheelagh to give us some of the detail, if I may, since she deals with that on a day-to-day basis. However, it is my understanding that we have agreed the common definition, we have a new set of codes, we have a method of collecting them into the Datex system, and we will be in a position to interrogate those data and give you a response that you have never been able to have previously, given how it was. Looking from a community-wide basis, Sheelagh may want to say something about primary care, where there is still more work to be done.

[29] **Ms Lloyd-Jones:** As Paul says, within secondary care, we anticipate that we will be able to analyse and monitor data across Wales certainly from October. In primary care, the situation will not be so easy, as I do not think that they have Datex as the NHS trusts do. However, if we are now creating local health boards, that is a key action for us: to look at how we get the same data across the health service so that we can monitor and understand what is going on and where.

[30] **Michael German:** Given what you have just said, how can we be certain that the figures that you have had in the past six months are robust enough, given that they have come from only a part of the health service as a whole?

[31] **Mr Francis:** I will come in there, if I may, Chair. The answer is that we cannot say that they will be totally robust. Among the first measures that we took in taking the taskforce's recommendations was to recognise that we had to expand quickly and engage with primary care; hence the early meetings with Richard Lewis of the BMA. That work is ongoing now, recognising the independent status of primary care. We are intent on building up that picture, but it is work in progress.

[32] **Mr Williams:** Could I just supplement that? It is an important question. We need to differentiate between primary care, with the remit of independent contractors and GPs, and the vast majority of community staff, such as community nurses, health visitors, community mental health workers, who are part of the trusts. I am not belittling primary care contractors and their staff, but the vast majority of staff are working in the community, and those data are collected within the trusts. All the trusts, apart from one or two specialist trusts, are integrated. We are not referring only to hospital employees.

[33] **Michael German:** From what you have just said, even in secondary care, we get only part-reporting across Wales. We cannot be certain that the responses that you are getting from part of the healthcare service, in secondary care, reflect the other part. It is 50/50, from what you are saying. We do not have a full picture for Wales here.

[34] **Mr Williams:** I do not think that it is 50/50.

[35] **Michael German:** If I remember correctly, you said earlier that 50 per cent of the health trusts were now reporting.

[36] **Mr Williams:** Yes. Sorry, I thought that you meant 50 per cent of staff in the community—

[37] **Michael German:** No, 50 per cent of the secondary care health trusts are reporting, and 50 per cent are not.

[38] **Mr Williams:** What I said was that 50 per cent of the trusts are probably in the higher quartile of performance reporting training. By October, we will have all seven new organisations complying with our requirements, and 50 per cent of those are already doing so.

[39] **Michael German:** I get the picture.

[40] **Irene James:** I want to look at paragraphs 1.13 to 1.15, which state that all trusts have now have appointed a violence and aggression champion. In the auditor general's report of 2005, he said that a senior member of staff was already responsible for tackling incidents of violence and aggression. Mr Francis, what will be different about the new champions, compared with the senior member of staff who was previously responsible for violence and aggression?

[41] **Mr Francis:** I cannot comment on the 2005 senior member of staff, but, on the current position, I can say that we felt it important to link the need to have clear plans that we could use to hold people to account and to measure progress locally, with having a named board attendee, a director, taking the lead. We felt that that was important. What we have now, which I feel is robust, is a named individual working to a clear plan with clear timescales, who can be held to account. I am not saying that that was not the case in 2005, but I am not able to comment on what it was like at that time, I am afraid.

[42] **Irene James:** Is anyone able to comment on what it was like before? If not, is there some way that we can have information?

[43] **Ms Lloyd-Jones:** The key difference is that the champion is a member of the board. That demonstrates to everyone that the board is taking first interest in the topic. A senior person does not necessarily indicate an executive member of the board. So, it is on the board's agenda.

[44] **Janet Ryder:** Paragraphs 1.16 to 1.19 say, as we have heard, that the Government does not have reliable data on the number of incidents of violence and aggression. However, they do show that there has been an increase in the number of serious incidents reported to the health service authorities. Mr Williams, do you know what is behind the increase in serious assaults and acts of violence?

[45] **Mr Williams:** I alluded to drugs and alcohol, and they seem to be the major factor, according to the information. We have looked at the information and, on the nature of the assaults, punches and kicks seem to be the main offenders, along with being struck with an object. People who are clearly under the influence are at least confused if not outright malicious. That is the issue that you really need to address, because there are other illnesses that can cause people to become confused, so you need to differentiate between them. While those ill people might still inflict a serious injury, their intent might not be the same as that of someone who is under the influence of drugs or alcohol, and who has heightened levels of aggression. I think that it is an issue that we have to deal with as a problem for society, as well as protecting our health workers.

9.50 a.m.

[46] **Janet Ryder:** That could explain some of the incidents, and why it is happening, but when it comes to the reporting of it, there has been an increase in the number of serious incidents being reported. Unfortunately, it has been the case, among many professions in the health service, that they accept a certain level of violence, in some cases, as you have alluded to, because of the illness that people are presenting with. It does not make it right, and it is not acceptable, but many staff have accepted that. For them to report it, it becomes a very serious

incident. Do you know what has led to that increase in the reporting of serious incidents?

[47] **Mr Williams:** We would hope that it is because of the efforts that we have been putting in. We have to be careful about zero tolerance, because there are cases where, clinically, there may be a good reason. It may be difficult to justify and we have to train people to deal with it, but, where we have society not respecting healthcare professionals and their job, that is where we have to be very robust in saying, 'This is not acceptable'. It is not right that healthcare workers just accept this as part of their day-to-day work, another pressure that they have to endure. It has to be unacceptable; we have to draw the line. I am hopeful that, because those messages have been coming out, people are now coming forward and recognising that the board, their managers and colleagues are supportive of them in this. It is a cultural issue. It may have crept in over the years in terms of less respect for healthcare professionals, but I think that we all agree that it has gone too far. We have to put all those measures in place now to ensure that it is eradicated in healthcare in Wales.

[48] **Janet Ryder:** Mr Francis, we have heard very clearly that it is a complex picture, but how soon will Government have in place the right strategies, the right initiatives, the right training and the right support to give a true picture of how violence is panning out across the NHS?

[49] **Mr Francis:** With the local plans, which are a national template, we already have that framework in place. It depends, then, on which aspect we look at. If we look at training, I think that that will probably take some time, because we have the focus on modules C and D, which you may want to discuss later. We are very much dependent upon the ability to analyse the data, which, as Mr Williams has said, will come in later this year, in terms of our confidence in being able to use it. Then, depending on which aspect of the action plans you were to look at, we have clear timescales set against various actions, so that, at any point, we could report on the progress against whichever element we are interested in. I am not sure whether you are looking at a specific issue, but, because it is such a broad series of actions, there will be different timescales for different elements.

[50] **Janet Ryder:** Could you give us a picture now, across the NHS, in which you would have confidence, or do we have to wait for some of those initiatives to kick in? If so, when do you anticipate that happening?

[51] **Mr Francis:** I could give you each plan, which could aggregate up to a situation in which I am confident that I know when I expect each employer to reach a certain stage in the action plan. In that respect, yes, I am confident that I can tell you what has happened and what we intend to happen over the timescales agreed. What I could not do now is say—well, the trouble is that, in the action plan, there are 26 actions, some of which are related, some of which are independent and, as we go through the year, we will be adding to that. So it very much depends which part of the progress you would want me to report on.

[52] **Janet Ryder:** So you are not in a position yet to give us a complete picture across the NHS.

[53] **Mr Francis:** I am not understanding the question.

[54] **Janet Ryder:** When will you be in a position to pull all those action plans and all those strategies together to give us that picture across the whole NHS?

[55] **Mr Francis:** I have got the action plans, which I could put on the table now, or bring in the next day or two, to show you, in each of the communities, the actions that we have agreed and the timescales that we have agreed against them. They do aggregate up, but it is not that simple. Let us take, for example, readiness in terms of the passport scheme. There

will be different elements and each employer will be at a different stage, but I could bring the plan that would show you by what date we have agreed that they will reach that standard we have asked for.

[56] **Janet Ryder:** Would you be able to tell us where each of them were against that, so that we could get that picture?

[57] **Mr Francis:** Yes.

[58] **Mr Williams:** Yes, on a makeshift basis.

[59] **Lorraine Barrett:** I have a question that, Dave Francis, you could have asked yourself a little while ago. Are you working with the police on what is behind the increase? Jonathan and I know that there are all sorts of reasons why, in the big cities, there are assaults and acts of violence. Are you working with licensing authorities, such as in Cardiff and Swansea and Newport? I guess that the majority of serious acts of aggression are drink-related and drug-related. So there is the police, the licensing authorities and you; are you working together? Is it the case that it is ambulance staff, on the front line, who bear the brunt of that? Are you doing some work on trying to defuse such situations? This relates to the work that Professor John Shepherd did—I do not know whether we will be taking evidence from him. Is any work being done on that and on how you can defuse the situation and deal with it before it gets to the hospital? It is an issue for ambulance staff and police and others to work on together. I am just trying to get a picture of whether you are all working together to try to resolve an element of the violence and aggression.

[60] **Mr Francis:** I think that I got most of the questions out of that. The answer is ‘yes’; we are working closely with the police and other agencies. I will give you some examples. You mentioned ambulance and accident and emergency departments: we recently did a joint-agency process-mapping exercise with the police, ambulance service and local authorities, tracking a sample incident kicking off in a town or city centre. Ambulance staff attended first and we then tracked that right through to the doors of the accident and emergency department and then through the hospital. That work was undertaken on 1 April and today’s steering group meeting will be agreeing that a task and finish group will pick up on the recommendations. We had support from the University of Glamorgan in doing that work. That is one example. Part of the local action plans are to ensure that employers link with community safety partnerships and have discussion on risk assessments for the threat of violence against NHS staff and, if the risk assessment stands scrutiny, to ensure that that is built into their action plans.

[61] I met with John Shepherd last week and had a discussion with him about the work that he is doing. At a high level, you will be aware that we are close to concluding the memorandum of understanding with the chief constables and I can also throw in that essential and pivotal to this joint work is the work that we are doing on case management minimum standards. The memorandum of understanding is one thing, but they very often just sit on a shelf, but this case management work will give life to that local relationship.

[62] **Mr Williams:** If I may just supplement that, Chair, I think that the work of the community safety partnerships is terribly important and the wider partnership agenda needs to be developed under local service boards. As Lorraine said, we need to look at the whole picture, to see whether we can address the way in which licensing is conducted and improve amenities or facilities within town centres and the night economy. We are looking at the possibility of drop-in centres to take some of the pressure off the main accident and emergency departments, so that some of those who are the worse for wear can be dealt with in different ways. On the ambulance side and CCTV, we are also going to have a pilot scheme for some crews and vehicles going out of Blackweir in Cardiff to ensure that ambulance

colleagues feel fully engaged within this initiative.

10.00 a.m.

[63] **Bethan Jenkins:** It has already been alluded to, but I want to ask about the passport scheme for training of staff and the fact that the report suggests that some people are still not receiving the basic training to which they are entitled. We also had evidence from the Royal College of Nursing that non-registered healthcare support workers were not receiving support from their managers to take up that training. How many staff out there still need to receive the basic, minimum training? Can you expand on what the hindrance is to them accessing that training?

[64] **Mr Williams:** I cannot give you the number of staff who have still not had the training, because that comes back to one of the questions from your colleague earlier in regard to the fact that we have less than perfect implementation. If I can start with the experience of my own previous trust, in Abertawe Bro Morgannwg, in module A, we had 100 per cent of staff who were trained, and, when I left, we had reached about 87 per cent on module B. There are difficulties and David wanted to discuss the more challenging issues on modules C and D.

[65] The reasons are interesting. Providing training across the board, and particularly in these areas, is proving difficult in terms of releasing staff and making staff available, because of service pressures. There are also records of maybe a 40 per cent did-not-attend rate, so that, when you put the sessions on, staff do not turn up. Obviously, you cannot leave it there, so we have introduced things like an e-learning package so that some staff do not need to leave their desk or their ward, but clearly, there is a lot more to do here. I think, from my own experience, that it has to be linked back into performance management. In dealing with this, at board level, we would regularly see the number of staff who were trained, we tracked it and that was passed down the system as an essential element. Clearly, this has not been given the same priority elsewhere. We have a lot to do. I would expect that we can now capture much more accurately the number of staff we need to cover and we need to be consistent in the approach. I do not know whether Sheelagh would like to come in with any further detail on this.

[66] **Ms Lloyd-Jones:** Yes. It will be our intention, with the new health boards, to ensure that, in the performance management framework, we will be getting information around training and all information around violence and aggression. Paul alluded to the fact that, in Abertawe Bro Morgannwg, we got 100 per cent of staff through the basic module A; that was by linking it to induction. It was part of their induction programme to the organisation that staff went through that. As to how one works out which staff need further training, it is linked to the risk assessment in the area in which they work. It is a moving programme, so the figures you have one day might not be the right figures the following day. It is about ensuring that every organisation has a training strategy around these areas and means by which they monitor performance. That is what we will be ensuring.

[67] **Bethan Jenkins:** I note the progress that you are making on this, but do you think that it may be putting people at risk, especially in modules C and D? If module D is not being implemented in psychiatric units, are staff being put at risk, unnecessarily, because of the lack of action in implementing the modules that seem to me to be necessary in dealing with this issue?

[68] **Jonathan Morgan:** On the back of that, have you prioritised certain staff? It seems clear that if you have staff working in fairly intensive environments where patients or patients' families might pose a potential threat to a member of staff, prioritising that training for key groups would be essential.

[69] **Mr Williams:** Certainly from my experience, where we had high-risk areas, like a medium secure unit, there was significant training. Obviously, this is all about avoiding the incident, breaking away and only using some form of restraint as a last resort. This is a very difficult and somewhat controversial area, where we are looking for advice from directors of nursing services, in particular. It is an area that must be addressed. However, I think that you will find that, in areas of high risk, most trusts will have addressed this, because there are other reinforcers in the system here. The Health and Safety Executive has been coming in and looking at how effective trusts have been. The risk pool and Healthcare Inspectorate Wales have also been looking at it in terms of quality standards.

[70] **Mr Francis:** May I just add to that? It is important not to leave the committee with the impression that no training whatsoever in modules C and D is taking place. We need to link it, as Mr Williams said, to the fact that risk assessments are taking place every day and training is taking place. The issue is, with passport being a national standard, recognising the need to revisit modules C and D because of the complexities on either break-away or the restraints and holds, which is some of the work that will be taken forward as soon as possible.

[71] **Bethan Jenkins:** I note that, but the report says that, at the time of the launch of the passport scheme, it did not contain any guidelines for the delivery of module D. How can you square that with the fact that this is not actually happening on the ground with risk assessment analysis?

[72] **Mr Williams:** I can only give my own experience and I think that David is absolutely right to qualify what I was reporting back to you. In my own organisation, we had a significant amount of time invested in the approach to training in break-away techniques and, as they used to be called, control and restraint. However, there are different views about how appropriate those techniques are. The difficulty we have had is agreeing on an appropriate set of guidelines for Wales, because there are different views about this, professionally. However, I do not want to give the impression that nothing is happening.

[73] **Bethan Jenkins:** Will there will be national guidelines on this? Surely, if it needs to implemented across the board and streamlined, a national guideline will be necessary.

[74] **Ms Lloyd-Jones:** Work on that is ongoing at the moment, in collaboration with the University of Glamorgan, where there is a professor who used to work for Bro Morgannwg and who is renowned for his understanding of this area of work. We hope that, within about three months, we should get something.

[75] **Jonathan Morgan:** Before we proceed, could I just ask for one point of clarification? Sheelagh Lloyd-Jones, you mentioned earlier that, as part of the restructuring of the NHS, you will be ensuring that information on training is collected as part of the performance management framework. I am assuming that, at the moment, that does not happen, or certainly not to the extent that it should. What level of data, and what level of reporting, do you expect of NHS trusts currently? Or is it that they are not required to report on how many staff are actually trained, in a variety of training—not just on how they handle difficult situations? Is there no requirement at all on the NHS to report to you and to the Assembly Government on how staff are trained in a variety of areas?

[76] **Ms Lloyd-Jones:** In terms of training, there is, I think, within what is known as the annual operating framework, a requirement to report some information, certainly around incidents. I do not think that we have a robust enough requirement to have detail about all the training that is taking place. That is something that, as we sort out the passport scheme, will be part of the performance management framework. However, within organisations—Paul has alluded to where we worked, within Abertawe Bro Morgannwg—as part of local

performance management, we would expect to have detail of training being reported.

[77] **Jonathan Morgan:** Did the passport scheme stipulate that NHS trusts had to report back to the Assembly Government as to what proportion of staff was being trained?

[78] **Mr Williams:** I might have to take the lead on that question, if I may, Chair. Coming back to the earlier evidence, clearly I could not report on the number of trusts that had reached a high level of compliance, or had not, without that information being provided to the Welsh Assembly Government. Obviously, we have that information, but what it demonstrates is that 50 per cent of the organisations were not reporting up. There is an awful lot of work to do there, clearly.

[79] **Jonathan Morgan:** The point that I am making is that there was no requirement put on the NHS trusts to report, but some were reporting a level of success, because you obviously have some figures.

10.10 a.m.

[80] **Mr Williams:** There was a need or a requirement to report, because otherwise we would not have the figures. The issue for me is why poor performance was not picked up in performance management. In the comprehensive plans that we are putting together by October, these issues will be addressed. I will certainly expect to have this information available to me through my suite of performance indicators.

[81] **Jonathan Morgan:** We are, in essence, as a committee, auditing how policy translates into practice, and I am always conscious of the role of this Audit Committee. Could we—and I am happy to receive a letter from you—have an outline as to whether the passport scheme had any requirement built into it? I assume it did not although you say that you know about some of the trusts. I suspect that those trusts might have just reported it as they thought it was part of their natural role. Clearly, you do not have that full picture. As we are auditing current and past performance, obviously we do not know how the new system of performance management framework will operate when it is up and running towards the end of this year. It would be quite useful from our perspective to know what the requirements were in detail, in order to see what has happened and what is currently happening.

[82] **Mr Williams:** I will send a report on the detail, Chair. In my understanding, it was a requirement. We have reports from the Welsh risk pool going back as far as 2005, 2006 and 2007, and from Healthcare Inspectorate Wales on levels of compliance. I think that it is probably an issue of compliance, not reporting, but we will check on the detail.

[83] **Nick Ramsay:** Can I ask Mr Williams about the design of hospitals and improvements in this design, and specifically the introduction of CCTV? You mentioned this in one of your earlier answers. I understand that it is ongoing on four trust premises on a pilot basis. When will this pilot scheme be up and running and how long do you anticipate it running for?

[84] **Mr Williams:** First and foremost, this is not new. A number of trusts already have closed-circuit television and the issue is whether it is sufficiently sophisticated, particularly when looking at good evidence for prosecutions. The trial will be on high quality closed-circuit television. We will be starting that in the next two or three months, and we should be in a position to report back by late autumn.

[85] **Nick Ramsay:** Secondly, to Mr Francis—and Mr Williams might want to comment as well—will it work?

[86] **Mr Francis:** I am confident that it will work, as long as we are linking the results of the CCTV pilots with some effective case management, and that we link everything up. The Minister has already made it very clear that she does not expect to have money spent on CCTV pilots if everyone is not linked up to make sure that all their processes support that investment. I am confident that it will very much help the prosecution process.

[87] **Nick Ramsay:** Do you think that the investment in higher quality will directly improve the rates of dealing with cases of aggression?

[88] **Mr Francis:** I think that it will certainly improve the evidence we have available to take to the police. It will also act as a significant deterrent. We have not started what is on the blocks in terms of an awareness raising campaign. Once we are confident of that, we can start putting these pieces together and I think it will make a difference.

[89] **Jonathan Morgan:** During the last evidence session, in discussion with Chris Woolley, the chief Crown prosecutor and the chief constable of the South Wales Police, we were told that there were concerns about the technical ability of the current CCTV systems in our hospitals. I think reference was made to three, or possibly four, of the systems being evidentially capable, and the rest of them simply were not. I appreciate why there is a pilot scheme being done now because there is clearly some sort of deficiency. Do you think that has been the principal problem in the way in which you have interacted with the police and the Crown Prosecution Service, and that the level and ability of CCTV to monitor what has happened in our hospitals has simply not been up to scratch?

[90] **Mr Francis:** It may be an element, Chair, but I would not class it as the principal problem. One of the things this pilot will do is focus everyone's mind on the purpose of CCTV and how it fits into the overall process. There may well be examples of CCTV not having been used correctly in the past and not having been monitored properly. This is about getting the process and the equipment right to move on.

[91] **Jonathan Morgan:** I have the evidence in front of me. The chief constable said that of the 17 hospitals that have CCTV, only three have cameras that are of good enough quality to use their footage as evidence. I appreciate it is how you use the system, where you position cameras, how you record and monitor them. Ultimately, she said that the quality of that CCTV in all but three of them was not evidentially capable of helping to lead towards a prosecution. Do you accept that?

[92] **Mr Williams:** Yes, obviously. I would just comment that trusts that have used closed-circuit television over the years, in general terms, have probably not invested in catching up with technology because they are putting their money into healthcare. We now recognise that we have a situation which has reached intolerable levels in some places, and we are now saying that we have to divert money from front-line healthcare into closed-circuit television. The issue is that the health service has had to react to a problem that it is now facing in society. I make no bones about it—it means diverting money from front-line healthcare investment.

[93] **Lorraine Barrett:** I am looking at paragraphs 2.14 and 2.15—lone workers and the worker tracking system that was first suggested in 2004 but, as we understand it, has still not been implemented. The chief constable also told us that Airwave—the new national digital communication system being used by all UK police forces—is used to protect police and ambulance staff, as well as RSPCA staff. She also said she did not know whether the NHS kept an intelligence database in order to share information on high-risk individuals. Why has there been so little progress in obtaining the all-Wales lone worker tracker system? We can all think of midwives and district nurses who put themselves at risk by going into people's homes, not knowing what is behind the door. Do you have the funds to procure this system? I

wonder if Mr Francis could say something about learning lessons from the police and other emergency services to protect staff working on their own or in high-risk environments?

[94] **Mr Williams:** Some trusts have piloted systems to support their lone workers, but there have been some difficulties in determining a system that is effective. This is not just in Wales, but also in England. During our work and research we were able to discover that England is now identifying a system and going through a procurement process, but that is only after evaluation. We took the view that we would have a framework contract with England, rather than going through our own process and procurement. As soon as our English colleagues have completed that process we will be in a position to similarly award tenders on that framework contract. This year we have set aside between £350,000 and £500,000 to implement that.

[95] **Mr Francis:** If I could just pick up on the other part of that question—there is no doubt that we can learn from the police and that is why we are working closely with them. Scheduled in the relatively near future is another part of this process mapping—which I mentioned earlier—to look at the lone worker position and, again, to ensure that we have a minimum standard of protocols across Wales. Having a system is one thing, but if we do not have the protocols in place and know that we will get the response that we need, when it is needed, it would not bear out the investment.

[96] Airwave is not as simple as was suggested. It may be relevant for front-line ambulance staff but I am not sure that it would be the answer for lone workers. If I could pick up the other part of the question about the intelligence database—you are absolutely right, there is not an efficient link-up yet. Again, that was part of the process mapping work of 1 April. The steering group that I chair has information sharing as a standing agenda item and there will be a group looking at that because a significant amount of work is needed. Ambulance workers know things that accident and emergency departments do not and vice versa. We need to link that up as quickly as we can.

10.20 a.m.

[97] **Mr Williams:** Just to expand, if I may, on my response in case I did not make myself clear. On the appropriateness of the device, obviously, a device which is appropriate for a uniformed police officer may not be the same for a district nurse or a mental health worker in an informal setting. We have to be sensitive to what we are doing, which is providing care for people, but at the same time providing appropriate protection for our staff. There are issues about the appropriateness of the device.

[98] **Lorraine Barrett:** I was thinking about the Suzy Lamplugh Trust, and the lessons learnt from that situation about people going into homes alone. Is there a system in place for lone workers in the NHS, to ensure that someone—a line manager or the surgery who have their list for the day—to know where an individual is at a particular time, and how practical would such a system be?

[99] **Mr Williams:** I do not think that you would find a sophisticated system, but there are risk assessments and information is passed between colleagues, management, and organisations.

[100] **Lorraine Barrett:** I think there is still a bit more work to be done on lone workers. You can think of all sorts of scenarios, but there are practicalities involved as well.

[101] **Jonathan Morgan:** If we move to part three of the report—it states in paragraphs 3.1 and 3.2, that when the auditor general first reported, security staff were not always available to help with incidents and security staff did not always manage them satisfactorily. This question is for Paul Williams—has there been any increase in the numbers of trusts that employ security guards and is the quality of the service they provide adequate?

[102] **Paul Williams:** I do not have the numbers of staff employed as security guards. I do not think that we collect that information so I would have to discover that for you. It has been very much an issue for trusts as to how they want to deploy security. Some have contracted out although, increasingly, that is not the case. We would have to look at that for you. The importance is of giving our front-line staff comfort in relation to physical security, through better design or the presence of support within the department. That should be constantly risk assessed within each trust to ensure that they have the appropriate level of cover. There will be different approaches to reflect different circumstances.

[103] **Jonathan Morgan:** David, do you think that the lack of dedicated security teams causes real problems?

[104] **Mr Francis:** I would not say that it causes problems, Chair. The issue is that, at the moment, security staff across Wales will have different job descriptions and different levels of training—some will be in-house, some will be contracted. There is no such thing as a generic security staff member. The difficulty, when we look into this, is that we can look at accident and emergency as a classic place where you would want security staff, but incidents of violence and aggression happen across the hospital. There are many stories of security staff having to run from one department to another. It is the early stages, but work is being undertaken to look at the training, the standards, and whether it would make sense to have an all-Wales approach. I know that the chief constable mentioned accreditation, and I am interested in pursuing this with her, perhaps on a broader field. I am sorry, Chair, the answer would not be to say that we will just have security in accident and emergency waiting for an incident to happen, because of that flow across the hospital and in the grounds.

[105] **Mr Williams:** As you will know from the report, certain trusts have been able to either provide facilities for police such as a room or accommodation, and some have police coming in on a regular basis. There are various approaches here, and it is an important area where we need to look at best practice and have some consistency. As I said, it varies from organisation to organisation, in different parts of the country, from proximity to urban or rural environments and so on.

[106] **Bethan Jenkins:** How can you qualify saying that many of the trusts do not use security staff that are contracted out? We had evidence from the Royal College of Nursing or the British Medical Association, saying that there were a large number of security guards who were working at supermarkets during the day, then coming into work in the evening and not knowing what to do or how to deal with situations. Is that not an argument for streamlining?

Mr Williams: Yes it is. The point I was making is that, in line with the ‘One Wales’ commitment, we are using staff who are contracted out less and less. However they are employed, they must have good guidelines and training. It would be indefensible if we had people coming in from another job, moonlighting, with no idea how to conduct themselves within the policies and guidelines of an organisation. I would hope that is not the position. There is still more work to do on this because the issue facing trusts is a question of balance. The more staff they employ in security, the more money is taken away from front-line services. However, they have to balance that with protecting their staff. It is a constantly shifting situation that needs to be risk assessed. However that risk assessment is executed, we need to make sure that the staff who are there are operating against good guidelines, are trained and are appraised to ensure that they are complying with those guidelines.

[107] **Lesley Griffiths:** At our last evidence session there was a conflict in some of the information that was given. The trust and staff representatives said that there was difficulty getting the correct response and attendance from police, while the chief constable said she felt that her staff were constantly in accident and emergency departments, particularly at weekends. Mr Francis, with your former hat on, why do you think there have been problems in securing the right assistance from police in hospitals?

[108] **Mr Francis:** I would not accept that, as a totality, we do not get the right response from the police. One of the difficulties is that the answer lies in the middle somewhere. We often get a very good response from the police and then, on occasions, we will have police officers who are run ragged and have many calls waiting. They will attend, deal with a flare-up, feel they have dealt with it and move on. You may then have a classic situation where the NHS staff will be left with a situation which will either flare up or has not been properly defused. That leads to this difficulty and confusion. At the risk of sounding boring, the answer lies in much closer working between health organisations and the police, and an approach of jointly owning the incident. That is what we are pushing forward on a case management approach so that we can get away from police blaming health organisations, and health organisations blaming the police. We jointly own the problem and that is certainly accepted on the ground with the police.

[109] **Mr Williams:** All this work is being done through senior managers sitting down with colleagues in the police and the other agencies, discussing wider issues. From that, an enormous amount of benefit and understanding starts to flow. There really needs to be support in the community partnerships in this area.

[110] **Lesley Griffiths:** In relation to the memorandum of understanding that is due to be signed by the Welsh Assembly Government and the police, we were under the impression that was going to be signed last week. Mr Francis, I think you just mentioned that it was going to be signed shortly. Mr Williams, why is there so much delay in the signing of this?

10.30 a.m.

[111] **Mr Williams:** It has not been intentional. The issue has been around the discussion and getting the organisations together. I would not want to give the impression that nothing has been happening in the meantime. This should be the final brick in the wall, as it were, because there has been significant improvement. I know that David has been engaged in part of these discussions.

[112] **Mr Francis:** I need to take some of the responsibility for this, because a draft document was available as long as a year ago. When I was appointed, I took a look at it and asked whether we could revisit it as I felt that it was far too broad for what we were trying to do in focusing on violence and aggression against NHS staff. The delay is partly my fault, therefore—if there is fault. As Mr Williams has said, we are now close to finalising that agreement, which we will then take forward.

[113] **Lesley Griffiths:** A year is a long time.

[114] **Mr Francis:** I cannot argue with that, but it has taken some discussion. Again, I do not want to give the impression that we were at different ends of the spectrum, but one of the issues that we needed to work through was that of private prosecution, which links to the CPS

MOU, because that is a very difficult issue for both the police and the CPS. In the earlier documents, there was an idea that, 'If the police will not do anything, we will take on a private prosecution'. The emphasis that I have been putting on this is that, if we gather the evidence properly, private prosecutions should become the exception. I hope that makes sense. That was where some of the discussion and delay was: working through whether private prosecution was appropriate or not and how to get the relationship with the police and the CPS right.

[115] **Lesley Griffiths:** Can you give us any indication of when it will be signed?

[116] **Mr Francis:** I cannot, but it is just a question of logistics now and getting some busy people together to finish that off.

[117] **Lesley Griffiths:** Given that there is concrete evidence that where police are present in any departments there is a decrease in the number of incidents, why do we not have a more general police presence in hospitals?

[118] **Mr Francis:** The type of cover that we would need in order to ensure protection was costed at about £9 million plus per year. That was at police community support officer rates, which throws up a problem, because they are neither trained nor employed to deal with violent incidents. So there is that element. A positive part of the answer is that, as Mr Williams mentioned, there is a police presence already. Some of the work that we are doing involves looking at the possibility for co-location on estates in the future.

[119] Sorry, I lost my track there. That work coming together will probably take us forward. I am in the process of doing another piece of work with the assistant chief constable in South Wales on hospitals in the heart of the community. So it would not be seen in terms of whether the police will call into a hospital, but, with the hospital being at the heart of the community, what it is entitled to in terms of police presence. Again, we are working through that.

[120] You will know that police officers on the streets are fairly sparse and so we need to strike a balance between them being in the hospital and them covering the streets.

[121] **Lesley Griffiths:** Do you have anything to add to that, Mr Williams?

[122] **Mr Williams:** We need to facilitate this. With regard to the hospital being at the heart of the community, we were talking about issues such as whether we can offer meal breaks for the police, for instance. If they are on patrol, perhaps they could call in and have their meals in the hospital. It is a partnership. Money will become increasingly tight for all public organisations, so are there ways in which we can complement what we are doing and, at the same time, reinforce each other's roles? I think that there is more work to be done here, but I cannot see us being able to sensibly say that we can encourage a step-up police presence of any significance in any departments because of the costs that David outlined.

[123] **Lesley Griffiths:** Okay. Thank you.

10.40 a.m.

[124] **Janet Ryder:** I want to look at the support that staff who have suffered a violent incident receive. Paragraphs 3.7 to 3.10 show that health bodies need to improve the speed at which support staff receive therapeutic support following an incident. Can you tell me, Mr Williams, what the Assembly Government is doing to improve access to support services, such as cognitive behavioural therapy and physiotherapy?

[125] **Mr Williams:** We might want to spend a bit of time talking about the role of the case worker. That needs to be available to individual members of staff from the moment the incident happens and right through. If part of that is about stress counselling, that should be provided. Also, if staff need treatment, we talked in another session about how we fast-track our staff if they need physiotherapy or any other treatment to ensure that we have an effective occupational health system. That may be a more appropriate way of dealing with some of these things than having hospital appointments. No matter what it is, for me it now has to be about the case worker, the way case workers are managed, and how the culture of the organisation insists that this happens so that people are fully embraced within the system and have that support and have confidence that any injuries will be dealt with properly, and that the prosecution that needs to taken forward will be handled in such a way that there will be a successful outcome. We have a lot of work to do here in terms of case management. I know from the various actions that I have seen in the employer's action plan that all these threads have been pulled together, including monitoring the effectiveness of the occupational health system.

[126] **Janet Ryder:** So, are you confident that the case worker will support the member of staff affected by incidents of violence and will increase the number of prosecutions by working closely with the police and Crown Prosecution Service?

[127] **Mr Williams:** Yes.

[128] **Janet Ryder:** So, you are anticipating that we will see an increase in the number of prosecutions.

[129] **Mr Williams:** Yes.

[130] **Janet Ryder:** We have had it made clear to us in evidence that there is a need for prompt feedback on incidents to staff. Mr Francis, are you satisfied that enough is being done to provide better feedback to staff, or could that be improved?

[131] **Mr Francis:** It can definitely be improved. I am not saying that it is bad—it will depend on where you are in Wales—but it can definitely be improved, and that is the purpose of agreeing, hopefully this afternoon, but certainly within the next two weeks, a minimum standard for effective case management. That will have the victim at its heart and the requirements will be along the lines of a daily review of incidents and early contact with the victim to ensure that the victim knows what is happening. There will also be regular feedback to the victim so that he or she knows what action is being taken or, if no action is being taken, why that is the case. I am confident that literally within weeks we would have those minimum standards available to you so that you can see how that is being put in place.

[132] The previous question is a good example. You asked how we would know when. In the local action plans that are in place, actions 16 and 17 specifically deal with urgent interventions in terms of psychological support and occupational health support. They are in place now in terms of the action plans and they will be tested in due course. That is an example of where a specific has already been laid out.

[133] **Janet Ryder:** So, when you get these guidelines signed off this afternoon, we will not hear again that it depends on where in Wales you are talking about. It will be common practice across Wales, and this will operate across Wales.

[134] **Mr Francis:** I am sure that you would not expect me to give a 100 per cent guarantee. What I can say is that the standards will be there and that every employer can be expected to be tested against those standards. As months go on, whether it is the Health and Safety Executive or the Wales Audit Office that will be involved, I am sure that those

organisations will take an interest in how employers are applying those standards, as will Mr Williams.

[135] **Janet Ryder:** How crucial to that process is the case worker?

[136] **Mr Williams:** The case worker is crucial. It is a massive step forward, and an innovation. Obviously, there will be a need to train and develop these individuals and to make sure, as part of the monitoring, that they are effective in their work.

[137] **Janet Ryder:** Do you have a picture of where they are employed across Wales? Does everybody have uniform cover of them or is there a lot to do to recruit staff? Is there still a lot to do to recruit case workers?

[138] **Ms Lloyd-Jones:** They will not be recruited as such; they will be people who are currently employed who are developing into this role. They will probably be people who currently work in areas such as risk management, so it will be a question of developing them to understand this new aspect. One person in an organisation that could employ 16,000 will not be able to cover what might be the load, so we have to have a group of people trained to the standard required to carry out the role.

[139] **Irene James:** I would like to look at paragraphs 3.11 to 3.15, which state that trusts have found it difficult to secure prosecutions against offenders committing violent acts against staff. The chief crown prosecutor for south Wales told us that the CPS does not routinely classify cases as being from the NHS. Mr Francis, there are around 8,000 cases of violence and aggression reported each year. Why do you think the rate of prosecution is so low? You mentioned private prosecutions, but is there another option if the case is not taken up by the NHS?

[140] **Mr Francis:** I cannot give a definitive answer to that. Part of the reason is the lack of reporting. A significant part of it will be the quality of evidence that we gather. Part of it may be that the victim may not want prosecution, because a large proportion of the 8,000 cases will be assaults or violence from patients in different settings. I would feel a lot more confident in six or nine months' time when we have the data breakdown on the areas where the assaults are taking place. My focus would be on trying to get to the bottom of how many cases warranted prosecution where we failed to take the case forward. I do not have those data at the moment.

[141] **Mr Williams:** As a broad indicator, from the earlier evidence, there is something of the order of 80 serious incidents and we would certainly need to be looking at those. I would not want to minimise any of these, but the vast majority are minor. We would need to find out, if we got 60 or 70 serious incidents, how that figure would compare in terms of the number of successful prosecutions.

[142] **Jonathan Morgan:** On 25 March, when the Royal College of Nursing came to give evidence and then later the chief crown prosecutor, along with the chief constable of South Wales Police, my colleague Nick Ramsay asked a question about the level of legal redress and touched on the issue of the type of criminal offence that is caused when somebody attacks another individual. An NHS worker is covered by the same law on assault as an ordinary member of the public. The question was put to the Royal College of Nursing as to whether or not the law should change to give nursing staff and other staff within the NHS the same level of protection as the police, or certainly for the offence to be considered the same as if there were violence against a member of the police force. The Royal College of Nursing said it thought that nursing staff and others should have the same level of protection in that sense and the chief crown prosecutor, Christopher Woolley, said there may be a case for doing that. I wondered what your view is and what the view of the Assembly Government might be.

Although this is not a devolved matter—it would be a matter for the Ministry of Justice and Department for Constitutional Affairs—do officials have a view as to whether or not the law ought to be changed to give medical staff and those working within the NHS the same level of protection as the police?

[143] **Mr Francis:** There is a case to be made as to why we should differentiate between nursing staff and the police in that regard. Equally, there is an argument against it. My focus is not on whether we should have additional powers, but whether we are using our current powers to full effect. The answer to the latter question is 'probably not'. However, I am not speaking definitively against new legislation; it is a matter of personal view.

[144] **Mr Williams:** I would tend to support that. This is not a devolved matter and we need to work with the material we have. Clearly, there is more that could be done in terms of achieving successful prosecutions.

[145] **Jonathan Morgan:** Okay, thank you. I see that there are no further supplementary questions. I thank our witnesses for attending this morning and, as usual, we will send you a copy of the transcript in a few days' time. Many thanks.

10.45 a.m.

Trefniadau Trosglwyddo mewn adrannau Damweiniau ac Achosion Brys: Gwybodaeth gan Archwilydd Cyffredinol Cymru
Accident and Emergency Handover Arrangements: Briefing from the Auditor General for Wales

[146] **Jonathan Morgan:** We have all been circulated with a copy of the report. It was published on 23 April and the auditor general advised the committee at the last meeting that the contents of this report could have a bearing on the committee's ongoing inquiry into ambulance services in Wales. I will ask the auditor general to make some introductory remarks and brief the committee on the main findings of the report. The committee has had the chance to read the report already and during the private session later the committee will need to decide under our new procedures how to proceed with this new report.

[147] **Mr Colman:** Thank you, Chair. I will say a few words to set this report in the context of our general approach to unscheduled care. My colleague, Rob Powell, will then give a little more detail about what the report shows. The history of our taking an interest in unscheduled care dates back to our first report on the ambulance services in Wales two years ago, when we found—as I think is well known—that the performance of the ambulance service in dealing with emergency response was very poor indeed and that the reasons for poor performance were not particularly related to shortage of money. The reasons for poor performance primarily were a failure to match the resources that were available to the demand for the services, which, by definition, is unscheduled demand, but that does not mean that it is unpredictable. Subsequently, last year we published a report on the management of chronic diseases, which showed that a surprisingly high proportion of acute secondary care facilities are occupied by patients with chronic diseases, who are there as a result, in many cases, of an unscheduled incident. That suggested to us that unscheduled care was an issue that bore upon the effectiveness of the whole system of healthcare in Wales. Therefore we decided to carry out a series of studies that would illuminate this important but very complex subject.

[148] The current report is the first in this new series. You could argue that it is the third or fourth, because we have done reports in the past that are relevant to the subject, but, following the decision to have a series of reports, this is the first and it focuses on what might strike you as a very small part of the whole system. It is a small part; it is an incident that should happen

within a very few minutes, with every patient taken to an accident and emergency department by the ambulance service. The report shows, however, that in an unsatisfactorily high number of cases the handover is not completed within a few minutes but can take over an hour, with severe consequences obviously for the patient, who is kept waiting, but also for the patient who is not in a hospital but is waiting for an ambulance out in the community. So this is a small part of the process but one with very important consequences.

[149] The findings of the report indicate that the Assembly Government is alive to the importance of the issue and has recognised its importance by setting a target for handover times. However, the method by which that target is measured and monitored was not very satisfactory, certainly at the time that we were doing our work, towards the end of last year.

10.50 a.m.

[150] The reasons for that are primarily to do with human factors: the ownership of the target and of responsibility for minimising handover times. It is interesting that, in the session that we have just had, there was quite a lot of talk about the ownership of issues. It is absolutely crucial, in whole-systems questions such as this, that staff recognise how their activities fit into the whole system, whoever their employer may be. That is all that I want to say by way of introduction and context. I will now hand you over to Rob.

[151] **Mr Powell:** Thank you, Jeremy. I want to talk Members through the context of the project in a little more detail and some of the main findings in the two parts of the report.

[152] You will be aware from the previous reports that we have done on ambulance services and the recent update that you considered last month that the Welsh Ambulance Services NHS Trust has lost a significant amount of time during turnarounds at accident and emergency departments. Turnaround is the time between an ambulance arriving at the hospital and becoming available to take the next call. There has been a long-standing debate as to whether the time lost arises from delays in handing over a patient to the hospital staff or whether there is a contributory element following handover that causes a delay in the ambulance crews making themselves ready to take the next call.

[153] The Minister for Health and Social Services, recognising that there is a problem, has set a new target to handle handovers, as opposed to turnarounds, and has introduced touch-screen technology at the ambulance entrance to emergency departments. This is to measure whether handovers have met the 15-minute target. Good practice across the UK suggests that turnarounds should take about 20 minutes, which is made up of a 15-minute handover plus five minutes for ambulance crews to restock the vehicle and get themselves ready to take the next call.

[154] Touch-screen technology is operated both by the ambulance crews in indicating their arrival at the emergency unit and then by the hospital staff in indicating the completion of the handover. The technology was installed in September 2008 to measure progress against the target, which came in during last year's annual operating framework.

[155] Jeremy mentioned that we are doing what we call whole-systems work on unscheduled care. So, we are not looking at one small element of the system, such as ambulance services or emergency departments; we are trying to look at the issues from the perspective of the citizen. Quite often, when one looks at a system, problems are found at the interface between different services. This report is a classic example in that respect.

[156] There are potential benefits in measuring handover times. It is probably a better indicator of the patient's experience than the turnaround target, which relates to the availability of a resource. Obviously, clinical risks increase if patients are left on trolleys or in

the care of ambulance crews, or even ambulance officers in the accident and emergency department who are there specifically to look after patients to free up ambulance staff to go back onto the road. There could be a lot of discontinuities and additional handovers that increase risks, not to mention the risks for those in the community waiting for an ambulance that is stuck at the emergency unit. If there are large numbers of ambulances outside the emergency unit or large numbers of patients on trolleys, it does not give the best impression of the operation of the whole system. In addition, it is not very good for the ambulance crews or the staff in emergency units who have to deal with that stacked-up demand.

[157] So, we decided to look at this very early on. Rather than wait a number of months for the system to work, we felt that an early spot check of the new system would be sensible. The idea behind that was to try to support the NHS in making the measurement system work, and particularly to try to reduce the impact of long delays when patients are being handed over at hospitals' front doors.

[158] Between the end of October and the middle of December 2008, we undertook two spot-check visits at each of the main emergency units in Wales. We went at different times of the day and on different days of the week for a couple of hours. We observed the handover process and looked at the data recording. We talked to a very wide range of staff, from the receptionist at the emergency unit to the front-line staff employed by the ambulance trust or the hospital, to get their views on how the system was working and the main causes of the problems.

[159] As Jeremy said, the main findings of the report were that, although there have been some positive steps towards improving handover times, patients are frequently delayed for too long outside the accident and emergency department. The data on handovers are not yet sufficiently robust to tell anyone anything more than what we already knew about turnaround times. Critically, NHS organisations need to think about the whole system. Addressing whole-system problems will probably have the biggest impact on improving handovers, as implied by the Assembly Government's strategy, 'Delivering Emergency Care Services'. They also need to measure the extent of the problem in the short term to try to improve things.

[160] Turning to the detail, part 1 of the report sets out our findings on the measurement and scale of the problem. You will be aware that, in 2008, more than 32,000 ambulance hours were lost by crews waiting to hand patients over, and which failed to meet the 20-minute turnaround target. That has direct costs: the cost of the ambulance crews' time in 2008 was about £2.4 million. There is a further cost of about £330,000 because of ambulance officers being placed in emergency units to look after patients to try to free up ambulance crews. There are also much wider indirect costs that affect response times as ambulances try to get back to where they should be. The planning of demand and job cycles tries to correct itself, because the ambulance trust works on a 1-hour job cycle from start to finish. Turnaround times of 20 minutes or more can make it very difficult to get the job cycle right again and to have resources in the right place to meet demand. That applies particularly in the more remote areas, and the report has appendices that set out the very significant impact of that in particular localities.

[161] When the system really breaks down—and we were looking at it during December 2008, which was a time of prolonged and severe winter pressures—the situation can become much worse and can quickly spiral. Figure 7 and the detailed appendix 4, which gives the situation in each of the 22 local health board areas, show that, during December 2008, the ambulance trust was taking a considerable amount of time even to allocate resources to respond to calls. In some areas, it was taking more than eight minutes even to allocate a resource to respond to a call, let alone to respond within the eight-minute target. That is a symptom of the system breaking down, and it is a very vivid manifestation of some of these problems.

[162] It is worth reminding Members that this is a very localised problem. Figure 12 shows the position of the different hospitals. You will be reminded from that that the University Hospital of Wales and the Royal Gwent Hospital experienced particular problems. Nearly 12 per cent of turnarounds in 2008 took over 20 minutes at the Royal Gwent Hospital, and it was just under 8 per cent at the University Hospital of Wales. So, it is a variable picture, and that can make the problems on particular days all the more acute.

[163] The second section of part 1 deals with an ongoing problem with other emergency services transporting patients to hospital, which is a serious issue that we first reported in our original 'Ambulance Services in Wales' report in December 2006. The Assembly Government's policy is to have an integrated emergency response, and police and fire officers have a sworn duty to protect life and to take care of people. That can sometimes lead them to decide to take patients to hospital in the absence of an ambulance to transport them. When we reported in December 2006, we highlighted a monthly average of around 11 such incidents between January and August 2006. The position that we found between October and December 2008 was quite significantly worse than that, with a monthly average of around 30 such incidents of police or fire officers transporting patients to hospital. They were predominantly incidents that involved the South Wales Police and Gwent Police, although a handful involved the fire service. It was not an issue at all in north Wales. That has all sorts of implications for the ambulance service, the patients concerned and the individual police and fire officers. If a patient dies in police custody, it will automatically trigger an investigation by the Independent Police Complaints Commission. That is obviously very difficult for officers who have done their best to do the right thing in very difficult circumstances. So, that is quite a serious issue that is contributed to by issues of handover and turnaround. The joint emergency services group is very concerned about this and has formally raised the issue with the Minister. A task and finish group is ongoing to try to reduce the impact of this.

11.00 a.m.

[164] The final part of part 1, paragraphs 1.25 to 1.47, deals with the fact that the true extent to which handover delays take place is still not clear. The terminals were introduced to emergency departments with commendable speed, but early on there were some significant problems with reliability. There were frequent malfunctions. The training was reasonably well received, but the malfunctioning led to delays in the system actually being used. That meant that people could not necessarily remember the training. There was a problem with staff knowing what to do, but not necessarily knowing why they were doing it. That probably reduced the buy-in of ambulance staff and emergency unit staff to record the information properly. They are driven by issues of patient care and patient safety. I am not sure that, in rolling out the touch screens, it was made sufficiently clear to them that getting a grip on handover delays would make a direct contribution to improving patient care. There were issues of clarity about when, in the handover process, the handover should be recorded and who should do it. Variability between different emergency units added to the lack of recording. In December 2008, which was a period of fairly unprecedented demand and winter pressures, only one in five handovers was actually recorded. Figure 13 shows the variability between the different emergency units in that respect. The good news is that, as I understand it, the extent of recording is improving. However, to get a grip on handover times, all incidents need to be properly recorded. In the report, you will see photographs taken during our spot-check visits, and there are pictures of touch screens that were not working.

[165] In the absence of robust data about handovers, the turnaround information is the best available way to measure the impact of problems at the interface between the ambulance trust and the acute hospitals. The Assembly Government and the acute trusts have some concerns about the reliability of that information. It is not validated. We think that, in the absence of any other information, it is a reasonable proxy indicator for time that has been lost. We can

certainly measure trends over time. However, the key thing is to get the measurement of handover delays accurate and robust, and a lot of work is now going on to that end.

[166] As I mentioned at the start, the key thing is to improve the operation of the whole system of unscheduled care. Part 2 sets out our findings on the extent and effectiveness of that work. The problems at the front doors of hospitals relate to problems throughout the healthcare system, and addressing those problems is likely to have the greatest impact. People must understand the range of unscheduled care services that are available and access the correct service to meet their needs rather than defaulting to the emergency unit. There are many widespread issues around the management of capacity and patient flow. Problems at the front door of a hospital often reflect issues at the back door—and you will be receiving an update on our work on delayed transfers of care in the middle of May. Issues at the back door, in relation to patient discharge, affect the front door. Bed capacity in the emergency unit was the issue most frequently cited by staff. That is affected by bed capacity on wards and the ability to move patients through the system. Flow is a key thing here, and it is exacerbated by very high levels of bed occupancy.

[167] We found that there needs to be greater vision and leadership to find joint solutions to these problems, between the Assembly Government, the ambulance trust and the acute trusts locally. They must recognise that an integrated and seamless approach needs to be taken to move patients through the system as effectively as possible. There is a lot of work ongoing on this, and there are some signs of progress. When you took evidence from Paul Williams and Alun Murray in March, they provided evidence that response times were improving. Some stabilisation funding has been given to the ambulance trust. Action plans have been developed, both to try to undertake some quick-win, short-term actions to improve things, and to deal with some of the long-term causes of this, in a longer term action plan for unscheduled care from 2009-11. If it is implemented effectively, it should help to improve the system.

[168] We found that staff are very much committed to improving handovers and to delivering good quality patient care. However, there needs to be better work by the local bodies to inspire them to record information accurately and to understand why they are doing it. There needs to be better matching of hospital resources to peaks of demand to ensure that staffing levels and the staff mix in the emergency units are appropriate to meet demand. It must be ensured that in-patient bed capacity is available to move patients through the system so that they can be admitted to the emergency unit in the best way. Handover information should be used to support better management of capacity and flow. There did not seem to be a sufficient recognition of the potential of the data terminals to help with the day-to-day management of the system, rather than using them just to record hard-nosed data. I think that greater recognition of the scope to use the terminals would certainly help.

[169] Resourcing across the system needs to be looked at in the round. As well as looking at the number of ambulance vehicles and the number of crews, there needs to be a look across the system at how much resource is available in each part of the system to move patients through in the optimum way. There needs to be much greater consistency of practice in handovers between the different units, and appendix 2 of the report provides a checklist to that end. The things listed may seem to be very obvious, which everybody should be doing, but we hope that the ambulance trust and the local emergency units will use the checklist to assess where they are and to improve their handling of the handover process.

[170] **Jonathan Morgan:** Thank you, Rob. We will now move on to questions for the auditor general, or for Rob.

[171] **Michael German:** We will come to discuss what we are going to do, perhaps, but I ask you now to look at figure 2 on page 10. I want to understand the exact starting point and the exact endpoint of turnaround, as opposed to handover, which, as you have rightly said, is

crucial to understanding this. Is the starting point of the 15-minute target the actual point at which the details are entered on to the arrival screen, or is it when the patient and ambulance crew go through the door? Sometimes, ambulance personnel are waiting in the emergency unit and they say, 'I will hold on to the trolley for you; you get going.' I have observed that many times. So, can you say with clarity where that starting point is?

[172] Secondly, have you been able to do a subtraction exercise? In other words, taking the whole timescale—from the top to the bottom—of the six stages of figure 2, can you then extract the 15-minute target and see where we are on the parts of handover that are not included in turnaround? Or the other way around.

[173] **Mr Powell:** The time recorded for the handover target starts when the screen is pressed on arrival. So, if there is a delay there, there is a risk that it would not be picked up. The report includes some photographs that indicate that there might be a wait for a triage nurse to come to receive the patient.

[174] We were not able to do the subtraction exercise. That would be very difficult in the absence of robust data, but it should become easier as the system beds in.

[175] **Janet Ryder:** To follow that question up, should the time not start from the moment the ambulance pulls up at the hospital? What would need to change to allow that? Is it your job to look at what needs to change, or where do we need to look to find out what needs to change to ensure that that happens?

[176] **Mr Powell:** Certainly, ensuring that there is a timely recording of the arrival of the ambulance through the touch screens is crucial to getting good quality information.

[177] **Janet Ryder:** You have highlighted the incident at the Wrexham Maelor Hospital. There have been very few problems of this nature in north Wales, but a problem was created by the introduction of the touch screens. You have detailed in your report that the feeling of the ambulance trust is that the nurses are there to monitor the role of the ambulance trust. How much of that tension has been created because there are two trusts involved? Was it purely about the location of the touch screen, and are there lessons to be learned from that for the other trusts?

[178] **Mr Powell:** My understanding is that the problem related to the location of the touch screen, and it was seen as belonging to the nurses in the emergency unit. Generally, this report suggests the importance of dealing with the human side of an IT implementation as well as the technical side; it is about winning hearts and minds and ensuring that everyone understands what the system is for, how it is to be used and why it is there. There has been tension in some units—Wrexham Maelor being one of them—when the implementation has not worked as well as it might have, and one side or the other feels as though their performance is being monitored. In fact, I think that the Minister's intention with this target was to get away from that, and to set a target designed to improve patient care, which fell on both organisations in recognition that this is a systems problem.

11.10 a.m.

[179] **Jonathan Morgan:** From my perspective, there are a number of issues here that certainly cause a few alarm bells to ring. The first involves the accuracy of the picture, or the true picture. Although a data terminal will record when someone touches it and will then record when the ambulance has left, and therefore provides a picture to the Assembly Government as to handover and turnaround time, there is clearly potential for a time lag between the ambulance arriving at the front door and somebody actually getting to the data terminal to record that.

[180] There is also a separate issue that certainly caused me concern when reading the report, and that involves the potential for the ambulance crew to discharge its responsibility by passing the patient over to another member of the ambulance trust. When this target was envisaged and when the policy behind it, I suspect, was drafted, the whole idea was that this involved the ambulance crew discharging its responsibility by handing the patient over to the care of the medical professionals, not, in essence, playing pass the parcel—and that is what it looks like. I am sure that that helps the ambulance crew get back out onto the road, and that was the principal reason for the target, but, ultimately, in terms of patient care, I think that some serious questions would be asked about what happens to that patient, and how long that patient stays with the other member of the ambulance trust before being examined and placed in the care of the appropriate medical professional. So there is certainly, from my perspective, a concern there.

[181] I wanted to raise two particular points —

[182] **Michael German:** May I come in on that? I should have asked this when I was asking my questions. Is it only the hospital staff who can touch the screen or, in other words, the trigger? If you are passed to ambulance personnel, they cannot touch the screen either, if I understand the system correctly. Is that right? Is it only the hospital staff who can touch the screen and start the process?

[183] **Mr Powell:** It varies a little bit in different departments but, in theory, on arrival, the ambulance crews will touch the screen and then, on departure, the hospital staff will usually indicate that the handover has taken place.

[184] **Jonathan Morgan:** There are two points that I wanted to raise. The first is in relation to the impact on other emergency services. You refer to the 2006 figures of 11 patients per month, on average, being carried to hospital by a different part of the emergency services, and roughly 23 such incidents being reported in March of this year. You say in paragraph 1.24 of the report that

[185] ‘The Joint Emergency Services Group has formally raised its concerns with the Assembly Government and is working to achieve a sustainable solution to these problems’.

[186] Did the joint emergency services group outline what possible solutions it was considering?

[187] **Mr Powell:** It is certainly monitoring the extent of the problem and it has had a meeting with the Minister. There is a very recent task and finish group report, as I understand it—in the last week or so—which I have not yet seen and which we will look at. We are certainly proposing to work with the joint emergency services group to monitor the trends with this in order to report back in the whole-systems report on unscheduled care later in the year, because, obviously, 30 incidents of this type is a very high number each month.

[188] **Jonathan Morgan:** Moving on to the issues that you have raised under paragraphs 1.32 and 1.33 onwards, you talk about the attitude of staff and say that

[189] ‘Some staff do not record handover times because they are resistant to additional monitoring of their activities, they are uncertain of their responsibilities or they feel the data recording takes them away from their clinical duties’.

[190] I appreciate that you spoke to staff, but did they provide any evidence of where they were being taken away from their clinical duties in order to fulfil this new responsibility?

[191] **Mr Powell:** I think that this was a general point where, if you have seriously ill patients and you are trying to care for them in the best possible way and hand them over to another service in a clinically effective way, it is quite possible that, because of the duty of care, your first priority would not be to go to a touch screen to produce some data to help with the management of the service. I think that this probably relates to the way in which the use of the screens was rolled out in terms of why that data is so important. If you had good ambulance response times and these problems at the door of the accident and emergency department did not manifest themselves, you would not necessarily need to measure how long the handovers were taking, because you could assume that the system was working well. Perhaps staff did not understand as well as they might have that, given the problems with ambulance response times and getting ambulances back on the road and the impacts on patient care when there is a delay in handover or multiple handovers, as you have just described, it is actually quite important to get a handle on the situation.

[192] **Jonathan Morgan:** I am looking now at appendix 3, which looks at the trust level data, and speaking as somebody with a keen interest in Cardiff. I am sure that Lorraine would agree with that. The fieldwork that you did shows that, in December 2008—I will just use this as an example—there was a reduction in the average number of hospital transports to accident and emergency departments per week compared with November. However, the number of hours lost in December was higher than the number of hours lost in November. So, for some reason, the number of hours lost went up and the number of average attendees at accident and emergency departments transported via ambulance went down. There is obviously an interesting interlink there between the two. I am wondering how typical this picture is, or whether it is just the picture that we have now come to expect, particularly at the University Hospital of Wales, and similar also to the problems that we have seen at the Royal Gwent?

[193] **Mr Powell:** There are many factors involved in this picture, not least discharge from hospital at the other end of the system. I think that December was a period of intense pressure on the wider NHS and, clearly, the system was struggling. However, there is, as you rightly point out, an interesting trend here with the number of patients attending at the accident and emergency department falling while the number of lost hours rose. I think that UHW, as we show earlier in the report, and the Royal Gwent are probably outliers.

[194] **Mr Colman:** This, if you will forgive me, Chair, is a mathematical point. The thing that is most important in causing lost hours is the variability of the flow. So, the fact that the number of patients being transported has gone down may not help much if the number per hour is very variable. We have had some conversations with mathematicians at Cardiff University who have shown us very clearly that, even if all the capacity is just right for the total volume of patients, you can have very long delays if the patients are so inconsiderate as to arrive randomly. [*Laughter.*]

[195] **Janet Ryder:** You have talked about the pressures that can be created because of the backlog when people are not discharged, so that the normal hospital fills up and that seeps over into the accident and emergency department. Have you made any attempt to measure cases that might show, not an inappropriate use of the accident and emergency department—because presumably the people are ill—but incidents where, because of the change in out-of-hours care by doctors, there has been increased pressure and what impact that has had?

[196] **Mr Powell:** That is very much an issue that is part of the whole-systems work that is going on at the same time as this report, which will contribute to the whole systems findings. If you can get people to access the right level of unscheduled care services, that can help to allocate the resources in a better way. When Alan Murray gave evidence to you in March he talked about 60 per cent of people who attend the emergency unit not requiring an in-patient admission, which may suggest that some of them could have been safely dealt with at another level of care, such as out-of-hours care. However, it involves how people access these

different levels of service and understand what they are for.

[197] **Jonathan Morgan:** Are there any more questions? I see that there are not. Thank you. We will defer our decision on how to proceed with this report until we discuss the matter later in private.

11.19 a.m.

Ystyried Ymateb Llywodraeth Cynulliad Cymru i Adroddiad y Pwyllgor Archwilio 'Rheolaeth Ariannol yn y GIG'
Consideration of the Welsh Assembly Government's Response to the Audit Committee Report 'NHS Financial Management'

[198] **Jonathan Morgan:** This item relates to papers 3 and 4. I invite the auditor general to introduce his assessment of the Government's response to the committee report on this subject, and we will then discuss how to proceed.

[199] **Mr Colman:** Thank you, Chair. The subject of effective financial management in NHS bodies is one that, I think, will be with us for a long time, so we never intended our report on this subject to be the last word. The Assembly Government's response is largely satisfactory, but there are still some remaining issues that, in my view, need following up. I shall certainly be following them up in our own work examining financial management in the restructured NHS from October of this year.

11.20 a.m.

[200] My letter to you records a particular issue relating to recommendation 4, where the Assembly Government's response does not seem to be consistent with the committee's recommendation, and it may be that the committee might wish to write to the Assembly Government about that. I think that it is interesting that, in the year that has just ended, for example, there was widespread expectation and forecast in December that many NHS bodies would end the year in deficit. At the end of the year, however, I understand—this is obviously to be confirmed by audit—that none of them were. It sounds like a fantastic achievement, but there were streams of payments from the Assembly Government to individual bodies towards the year-end.

[201] In our report on the financial management of the NHS two years ago we drew attention to the fact that very late adjustments—including adjustments to targets after the end of the year to which they relate—were not really conducive to sound financial management. That practice still seems to be happening—at least, I understand that it is. I conclude, therefore, where I started in response to your question, Chair, by saying that this is a subject of continuing interest that will warrant continual investigation.

[202] **Jonathan Morgan:** Are there any views before I recommend one way to proceed? I see that there are not. One option, certainly, might be for me to write to the accounting officer and set out where we require further information and clarification, and particularly to have some indication as to when the Assembly Government intends to review the initiatives that have recently been introduced to improve financial management, but also to seek clarification around recommendation 4. I think that that would be quite useful, unless there are any other suggestions as to the way to proceed. I see that there are not. Is everyone happy? I see that you are. Good.

11.23 a.m.

Ystyried Ymateb Llywodraeth Cynulliad Cymru i Adroddiad y Pwyllgor Archwilio 'Gwasanaethau Therapi Ocsigen yn y Cartref'
Consideration of the Welsh Assembly Government's Response to the Audit Committee Report 'Home Oxygen Therapy Services'

[203] **Jonathan Morgan:** This item relates to papers 5 and 6. Again, I ask the auditor general to introduce his assessment of the Government's response. I think that, on this report, the auditor general seems satisfied with the Assembly Government's response, but I will ask him to outline how satisfied he might be.

[204] **Mr Colman:** We are always a bit grudging in that respect; it is our way as auditors. In summary, yes, we think that the Assembly Government's response shows that it has taken the work of this committee extremely seriously. I do not think that there was ever any attempt to pretend that the way in which the implementation of the home oxygen contract went was anything other than really quite poor. The response of the Assembly Government is a satisfactory one.

[205] **Jonathan Morgan:** I think that that concludes that item. Thank you.

11.24 a.m.

Cynnig Trefniadol
Procedural Motion

[206] **Jonathan Morgan:** I move that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 10.37(vi).

[207] I see that the committee is in agreement.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11.24 a.m.
The public part of the meeting ended at 11.24 a.m.