Work-based violence, harassment and abuse towards NHS staff in England

Extent, impacts, risk factors and options for action

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Contributions

NB led the call for evidence, analysed and drafted the section on extent and nature of violence, edited the report, and contributed to the discussion and recommendations, and report finalisation. EMC led the work package related to developing case studies, including development of the discussion schedule, speaking with relevant stakeholders, and drafting of the interventions section. ABR conducted consultation interviews and drafted case studies, contributed to triangulating findings and the drafting of the executive summary. RB analysed and drafted the sections on impacts and risk factors and supported the design of the final report. CS analysed and drafted the section on individual level risk factors. BB screened the results of the academic literature searches and reviewed and summarised the findings. LJ and ZQ designed the methodology of the work, oversaw project management and completion and contributed to report writing, editing and finalisation.

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Contents

Executive summary 1
1 Background 14
2 Nature and extent of violence against staff 17
3 Impacts of violence against staff 36
4 Risk factors for violence against staff 42
5 Preventing and responding to violence against staff 51
6 Discussion 69
7 Recommendations 77
8 References 80
Appendices 93

Table of figures

Figure 1: Patient/visitor violence, harassment and abuse against staff in Emergency Departments in England, by year and region. Source: Donald & Lindsay, 2023. 32
Figure 2: Patient/visitor physical violence against staff in Emergency Departments in England, by year and region. Source: Donald & Lindsay, 2023. 32
Figure 3: Physical assaults against ambulance workers in England, by year. Source: GMB Union, 2018. 33
Figure 4: Harassment, bullying and abuse against staff, by year and perpetrator. Source: NHS Staff Survey 2022. Figure 5: Physical violence against staff, by year and perpetrator. Source: NHS Staff Survey 2022. 33
Figure 6: Violence against staff incidence data 2020-2022, by perpetrator and violence type. Source: Leeds Teaching Hospitals NHS Trust. 34

Table of tables

Table 1: Prevalence of violence across studies, by setting/job role and nature of violence.. 28
Table 2: Frequency (%) of violence experienced by NHS staff, by perpetrator and violence type. Source: NHS Staff Survey 2022. 30

Executive summary

Background and methods

Violence, harassment and abuse in the workplace is a pervasive issue and evidence globally suggests that staff working in the healthcare sector are at increased risk of violence, harassment and abuse. Violence against healthcare workers greatly increased during the COVID-19 pandemic, and evidence to date suggests this upward trend is continuing. The World Medical Association has declared violence against healthcare workers a healthcare emergency and called for WHO and member states to act.

The NHS People Plan was published in 2020/21 with a strong emphasis on 'Looking after our People' and included 23 commitments related to health and wellbeing. One of the commitments is that all NHS staff feel supported, safe and secure at work. More recently, the NHS Equality, Diversity, and Inclusion Improvement Plan published in 2023 includes 'High Impact action 6' which seeks to 'create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.'

Leaders across the NHS have a statutory duty of care to prevent and control violence in the workplace. However, there has been no national NHS wide data collection of incidents of violence, harassment and abuse in place since 2016. This has limited opportunities to fully understand the nature, extent and impact of violence, harassment and abuse. However, there are a wealth of interventions and approaches being implemented at a local, regional, and national level to address violence, harassment and abuse towards staff. Understanding these approaches and interventions and how they relate to evidence on the issue is key to ensuring effective and sustainable action.

This report presents an evidence-based overview of the nature, extent and impact of work-based violence, harassment and abuse towards NHS staff and presents examples of practice in preventing and responding to violence, harassment and abuse. The report presents evidence and information on violence, harassment and abuse in NHS settings related to the following aspects:

1. Nature and extent
2. Risk (and protective) factors
3. Impacts
4. Reporting and recording practices
5. Interventions, programmes, projects, policies, frameworks, strategies or tools

The nature and extent of violence, harassment and abuse

Staff working in the NHS experience a range of different types of violence, harassment and abuse including: physical assault and aggression; verbal aggression, abuse or threats; sexual

abuse, aggression, and assault; discrimination and harassment; and bullying. As well as direct experiences, staff may witness their colleagues experiencing violence, harassment and abuse. Evidence on the extent of violence against NHS staff varies widely depending on context, organisation, job role, perpetrator, and nature of violence examined, but overall evidence indicates a high level of incidence and prevalence of violence, harassment and abuse. National level data suggests there are as many as 200 assaults on staff per day, with data from A&E departments suggesting an average of 80 incidents of violence, harassment and abuse per 100,000 attendances. National prevalence data from the annual NHS Staff Survey indicates that as many as one in seven NHS staff experienced physical violence from patients, their relatives, or members of the public in 2022 and one third have experienced harassment, bullying or abuse.

Violence, harassment and abuse are often repeated experiences for NHS staff, with evidence suggesting that they are both commonplace and frequent in nature. Many frontline staff, who have the most contact with patients and the public, experience multiple incidents of violence, harassment and abuse. Studies have found that violence against staff has increased in recent years. One UK study found that the rate of patient and visitor violence, harassment and abuse increased by over 40% between 2017 and 2021, with the biggest yearly increase occurring between 2019 and 2020. This suggests that the COVID-19 pandemic has had a substantial impact on rates of violence experienced by staff. While incidence data shows an increase in violence in recent years, prevalence data from the self-reported NHS Staff Survey indicates that levels of harassment, bullying and abuse and physical violence, have either remained approximately stable or decreased between 2018 and 2022.

The 2022 NHS Staff Survey showed that over half of all staff who experienced some form of harassment, bullying or abuse in the past 12 months had not reported the incident, whilst 28% of those who experienced physical violence did not report the incident. Barriers to reporting include staff's perception of the inevitability of violence and in some settings (such as acute mental health) a certain level of acceptance and expectation that patients with less capacity to reason may act violently towards staff. Other barriers include the perception that even if incidents are reported no further action would be taken, the burden involved in reporting an incident, or a fear that reporting the incident may be perceived as reflecting badly on their judgement or skill. Evidence suggests that a range of demographic and occupational factors are associated with reporting levels including sociodemographic factors such as gender, age and ethnicity, and occupational factors, such as occupation group, trust type, length of service and amount of patient contact.

Impacts of violence, harassment and abuse

There are a range of individual and organisational level impacts related to violence, harassment and abuse against NHS staff.

Individual impacts

Physical and mental health problems

Violence can severely affect the physical and mental wellbeing of individuals. Staff often report experiencing emotional distress, impacting their self-confidence. Witnessing abuse of their colleagues also impacts on staff mental health. Some evidence suggests that bullying and harassment by colleagues can have more profound effects on mental health than violence from patients. Evidence suggests bullying can create toxic workplace cultures that hinder job performance and further impact staff mental health, discouraging incident reporting and causing additional distress. Discrimination and harassment related to protected characteristics can also significantly harm mental health. Limited research exists on the physical health impacts of experiencing violence, harassment and abuse, but it suggests that physical violence can lead to debilitating injuries and symptoms affecting some people's personal and professional life.

Low job satisfaction

Violence, harassment and abuse profoundly impacts job satisfaction, morale, and staff intention to stay working within the NHS. A large representative survey of over 1,391 NHS London staff working across 30 different organisations, showed that those who experienced abuse were notably less enthusiastic about their job, lacked enthusiasm for work, and reported lower job satisfaction compared to their colleagues who hadn't encountered such incidents. This pattern was observed among trainees and students as well, leading to low job satisfaction and revaluation of their NHS career prospects.

Increased acceptability of violence

Cultures within the healthcare sector often encourage staff to "just get on with it," fostering emotional detachment and desensitisation as a coping mechanism. This attitude leads many staff to view exposure to violence, harassment and abuse as an inherent part of their job. This normalisation hampers incident reporting, particularly when staff perceive an expectation to tolerate such behaviour.

Worsening career progression or prospects

Staff may feel unsupported after an incident of violence. In some cases, managers and senior staff are seen as penalising employees for reporting such incidents, hindering their career progression. Other evidence suggests that there is a perception that reporting harassment, especially involving higher-ranking individuals, is often futile, as managers tend to protect each other rather than addressing these issues seriously. This discouragement of reporting also extends to students and trainees who often find their concerns about bullying and undermining disregarded or negatively affecting their academic or work progress.

Organisational impacts

Staff sickness absence

Incidents such as bullying and violent assaults may result in staff taking sickness absence due to physical and psychological trauma. This can have financial implications for organisations as increased staff absenteeism puts additional pressure on the health system, reducing staffing levels and increasing the risk of burnout for remaining staff members, as well as

prolonging treatment waiting times. In turn, staff shortages themselves may become perceived as a risk factor for violence, harassment and abuse, with for example, a large national survey of UK doctors finding that almost half of respondents attributed incidents of violence, harassment and abuse to staff shortages, with long treatment waiting times identified as a significant contributing factor to incidents.

Staff retention

Experiencing violence, harassment and abuse can significantly impact staff retention and increase the likelihood of staff thinking about leaving the NHS. Bullying and harassment from colleagues can lead students to drop out of training and placements, affecting future staff recruitment prospects.

Patient quality of care

Violence, harassment and abuse in the workplace can hinder staff from delivering high-quality care to patients as it can lead to demotivation, decreased engagement, and presenteeism among healthcare workers. Working relationships with colleagues may be affected. Staff may disengage from their work as a protective measure, further raising the likelihood of unmet patient needs and adding further burden to their colleagues.

Financial costs

Workplace violence not only has potential financial implications due to lower staff productivity, absenteeism, presenteeism and poor retention but also has significant repercussions stemming from potential litigation, compensation, efforts to improve public opinion, and the need to repair reputational damage. A 2019 study estimated an annual cost of £2.3 billion to taxpayers in England due to the financial consequences of bullying and harassment among NHS employees.

Risk factors for violence, harassment and abuse

The evidence shows that a range of factors contribute to both the occurrence of violence, harassment and abuse within the NHS and the impacts that follow. Violence, harassment and abuse are often framed as being rooted in individual behaviours, but it is important to recognise that systemic contributions are equally, if not more, important.

Individual (Staff member)

Professional position

Many studies identify professional position as a risk factor for violence, harassment and abuse, with nurses, healthcare support workers, and students being more likely to experience abuse from patients. Staff members working within security, nursing, and reception roles, as well as those who deal with patient complaints are particularly susceptible to verbal abuse. Senior staff are less likely to experience abuse, although they are not entirely immune. Workplace bullying tends to be perpetrated by staff with more seniority than the victim, creating additional concerns as managerial behaviour often sets the tone for the work environment and influences how staff members treat students and staff in more junior positions.

Level of experience

Studies suggest that there is a negative correlation between violence, harassment and abuse and length of experience in the healthcare sector. More experienced staff members are less likely to experience abuse, especially verbal abuse, highlighting that students and new employees are at a higher risk of violence and mistreatment. Workplace bullying may occur from senior staff toward junior staff and students, with behaviours like humiliation, withholding essential information, and setting unreasonable targets discussed across a variety of studies. In some cases, bullying may be fuelled by the perceived outsider status of students.

Level of patient contact

Direct patient contact time increases the risk of staff experiencing violence, harassment and abuse, but some studies show that despite an overall higher incidence among full-time staff, part-time staff face a relatively higher prevalence. However, these risks may be confounded by the cohorts of staff who are more likely to work part-time, for example female staff and those from ethnic minorities; demographics which are also associated with an increased risk of violence.

Demographics

Several studies indicate that demographic factors impact the risk of experiencing violence, harassment and abuse, with some victims attributing it to discriminatory behaviour based on gender, ethnicity, age, sexuality, or disability. Study findings indicate gender differences in the types of violence experienced, with some studies suggesting that women are more likely to experience verbal abuse and men more likely to experience physical abuse. Within ethnic minority groups, there is a higher likelihood of experiencing abuse, with studies suggesting that people from Black ethnic groups are most likely to report physical abuse. Employees with long-term health conditions or disabilities are also at a higher risk of experiencing violence, harassment and abuse.

Lack of adequate training

An absence of training in de-escalation techniques and in understanding the causes and treatment of pathologies related to violent behaviour were identified as risk factors in various studies. While NICE guidelines on the short-term management of violence and aggression recommend that NHS organisations provide staff training in de-escalation, reports suggest that staff may have unmet training needs and often skills gaps around recognising violence and aggression and taking appropriate preventive measures.

Communication skills

Effective communication, including talking to and comforting patients, may be a protective factor against violence, harassment and abuse although it is viewed as more preventive than an explicit de-escalation strategy. Conversely, poor communication skills were identified as a risk factor, with patients becoming agitated when information is lacking, or they feel ignored. Hostile attitudes and behaviours can escalate conflict, emphasising the importance of both verbal and non-verbal communication in resolving issues. Effective communication among staff is equally important for improving efficiency and information exchange at all levels of healthcare partnerships.

Workload and stress

High workloads, feeling overworked and stressed were identified as risk factors for violence, harassment and abuse. Stressed and overworked staff may struggle to de-escalate potentially violent situations and effectively communicate with patients. Workloads and stress can lead to patient frustration, further contributing to violent incidents. Workplace violence can in turn, cause stress and anxiety among staff, potentially leading to more employees leaving, exacerbating stress levels in the workplace, and increasing the risk of violence. High workload demands can also prevent the reporting of incidents. Studies indicate a link between workload pressures and workplace bullying and discrimination, with stressed staff sometimes perpetuating bullying behaviours due to frustration with others' performance. Managers, in particular, may face high workloads, which could explain their higher risk of perpetrating bullying behaviours. Stress within the workplace, whether among staff or managers, can contribute to aggressive behaviours.

Individual (perpetrator)

Substance use

Patient alcohol or substance dependence/misuse are recognised as risk factors which significantly increase the likelihood of violence, harassment and abuse. Alcohol and drugs are both linked to an increase in aggressive behaviour, with excessive alcohol consumption being particularly highlighted in some studies. Individuals with alcohol and drug misuse issues are considered more predisposed to violence. A substantial number of incidents, such as attacks on ambulance staff and cases of abuse, are attributed to perpetrators under the influence of alcohol or drugs. Reports indicate that intoxication is a key aggravating factor in violence, harassment and abuse, contributing to cases of both physical and verbal abuse. The potential links between substance use and mental illness (another key risk factor) is also critical.

Psychiatric conditions/mental illness

Serious mental health issues and psychiatric conditions are often significant factors increasing the likelihood of violence, harassment and abuse. Some patients may lack insight into their actions or display behaviours that appear disrespectful due to these conditions. Some research suggests that physical and verbal abuse is often linked to health or personal problems, particularly among patients with conditions such as dementia or mental health issues. However, it is equally important to note that not all individuals with mental health issues perpetrate violence, harassment and abuse. Overall, addressing violence related to mental health conditions remains a complex challenge in healthcare settings.

History of violence

Patients with a history of violence, whether personal or within their family or social group, are more likely to perpetrate violence in healthcare settings. A significant proportion of physical and verbal abuse may be attributed to perpetrators with histories of violence. However, whilst an individual level risk factor, a patients' history of violence needs be considered more broadly in the context of societal level factors for violence, harassment and abuse (including, for example, social, developmental and familial history).

Organisational factors

Insufficient policies or prevention work and ineffective management

Inadequate policies, guidance, and prevention efforts have been identified as significant factors contributing to the risk of violence, harassment and abuse in healthcare settings. Organisations are responsible for implementing protocols, policies, and risk assessments to prevent violence, harassment and abuse, and a lack of action can lead to serious consequences. Insufficient anti-bullying policies have been linked to a higher incidence of bullying. Inadequate protocols, incident records, supervision, support, and guidance for administrative staff also contribute to this risk. Ineffective complaint protocols, particularly for students, pose a problem, as many feel they are denied the opportunity to register complaints. Addressing disciplinary action, especially against senior staff members, may be challenging, with the perception that some bullies are *'untouchable*.' The lack of clear and consistent enforcement of rules and boundaries by caregivers is another significant risk factor, as assaults are often linked to a lack of explanation regarding ward rules.

Staff shortages

Financial deficits in healthcare organisations are strongly correlated with an increase in violent assaults. Financial struggles lead to staff shortages, longer patient waiting times, and increased stress among both patients and staff. Such pressures on patient services contribute to the rise in violent incidents. Additionally, these budget pressures are linked to an increase in staff-on-staff bullying. Work overload has also been identified as a contributing factor to bullying behaviours.

Environmental/situational risk factors

Waiting times

Long waiting times in healthcare settings are a major risk factor for verbal and physical abuse from patients towards staff. Long waiting times can cause boredom, frustration and impatience among patients and their families. Patient expectations on what constitutes reasonable waiting times is a key factor and can be exacerbated by a lack of information around wait times. Long waiting times can also cause worry and concern about the health and safety of the patient waiting for treatment.

Lone working

Lone working, which involves working without immediate support from other staff, is consistently identified as a risk factor for experiencing violence, harassment and abuse. Staff who work alone, such as community-based staff, delivery drivers, health visitors, and others, are more likely to experience violence, harassment and abuse. Lone working creates an elevated risk as staff lack immediate assistance to manage conflict or respond to situations involving known violent individuals.

Environmental design

The design of healthcare environments substantially influences the likelihood of staff experiencing violence, harassment and abuse from patients. Poor environmental design factors include insufficient information provision, limited access to amenities like TV or reading materials, a lack of private areas, and staff working in isolated spaces.

Prevention and response

Various national strategic and policy drivers support action on violence, harassment and abuse against NHS staff, these include: the NHS Long Term Plan; NHS People Plan 2020/21; NHS 2022/23 Priorities and operational planning guidance; NHS Violence prevention and reduction standard; Guidance for those caring for patients lacking capacity and the rights of such patients; NHS Long Term Workforce Plan and the NHS equality, diversity and inclusion (EDI) improvement plan. At a local level, all providers of NHS services have a statutory obligation under the Health and Safety at Work Act 1974 to prevent, minimise and control the risks of violence, harassment and abuse against their employees and they must have regard to the national Violence Prevention and Reduction (VPR) standard.

Workplace violence is a complex problem and it is widely recognised that the best way to tackle violence, harassment and abuse against healthcare staff is through comprehensive multicomponent approaches rather than implementing interventions and approaches in isolation. Taking a public health approach to violence prevention in the workplace supports multicomponent action and means that violence against NHS staff is seen as a preventable consequence arising from a range of human and systemic factors, rather than being seen solely through the lens of an isolated health and safety incident or as a security concern. Alongside an evidence-based overview of interventions and approaches, eight case studies are presented about interventions, approaches and strategies across NHS trusts, ICSs, and other organisations representing or linked to the NHS workforce.

Whole system approaches to violence prevention

The global evidence base suggests that strong leadership is necessary to both cultivate and enforce cultures that provide an environment for successful workplace violence prevention programmes. From the case studies it was also clear that multidisciplinary collaboration is crucial for the effective implementation and delivery of violence prevention interventions. Most case study interventions mentioned efforts to incorporate partnership working practices within their work and two case studies demonstrated examples of whole system leadership on violence prevention based around the National Violence Prevention and Reduction (VPR) Standard and a whole system public health approach to violence prevention. The key impacts of collaboration include gaining a more nuanced perspective of the issue; understanding and acknowledging the impact on service users; and increasing stakeholder engagement.

Intervention case study 1. Systems leadership: An approach delivered by NHS Sussex ICS detailing efforts to implement system wide policies, set up local partnerships and build a leadership culture focused on trauma-informed practice. The ICS is aiming to embed a trauma-informed, public health approach to violence prevention by March 2025.

Intervention case study 2. Community of Practice: A community of practice approach to support the implementation of violence prevention and reduction strategies has been introduced across NHS Suffolk and North East Essex ICS. This includes the development of reporting campaigns, supporting multidisciplinary working and shifting culture across all trusts.

Staff education and training

Staff education and training are an important component of violence prevention and response approaches. Education and training may cover a broad range of techniques including education to enhance knowledge and understanding of policies and procedures and violence control strategies including conflict resolution and de-escalation, and communication and restraint training. Specific programmes may target staff interpersonal skills and a trauma-informed approach to training aims to build understanding of the underlying causes of patient violence and aggression through a focus on emotional intelligence, communication training and reflective practice. All of the case studies discussed some element of staff training and one had a particular focus on training. It is important to note that while staff may gain knowledge and confidence from training, a recent Cochrane review reported low certainty in the evidence linking education and training programmes to reductions in violence, harassment and abuse against healthcare staff.

Intervention case study 3. Conflict resolution training: The Northampton General Hospital NHS Trust uses the NHS conflict resolution nationally mandated course and appeals to the empathy of healthcare workers. The programme equips a variety of staff to approach patient facing situations with compassion and consideration for their personal circumstances such as neurodiversity, trauma or cultural background.

Awareness raising and campaigns

Awareness raising activities and campaigns targeted at NHS staff and the public are a common component of workplace violence prevention activities but the effectiveness of specific campaigns is often not tested. Three case studies cover awareness raising activities and campaigns. #WorkWithoutFear is a social media campaign that aims to spread awareness of the violence, harassment and abuse faced by ambulance and emergency service workers.

Intervention case study 4: #WorkWithoutFear campaign: The Association of Ambulance Chief Executives (AACE) have launched #WorkWithoutFear, a national social media campaign aiming to raise public awareness of the abuse that ambulance and emergency service staff face on a daily basis.

Risk control and protective measures

A range of measures including environmental design, security technologies and changes to working practices have been implemented within the NHS to tackle violence, harassment and abuse. Environmental design and environmental strategies for workplace violence prevention are an important consideration, particularly so in accident and emergency departments. Examples of security technologies implemented within NHS settings include non-contact patient monitoring and management systems (for example, Oxevision), body worn cameras and personal alarms. However, the availability and strength of the evidence is currently limited across these measures. Working practices around the use of restrictive interventions are the focus of two case studies. The “No Force First” campaign advocates for the minimisation of restrictive practices with vulnerable patients by educating staff on alternatives techniques. A second case study demonstrates an integrated approach to violence, harassment and abuse in adult acute mental health care wards and psychiatric intensive care units across London.

Intervention case study 5. 'No Force First' approach in Mersey Care NHS Foundation Trust: This approach is aiming to reduce the use of restrictive interventions in healthcare settings treating vulnerable patients and to transform culture within acute psychiatric health wards across services that cover the North West of England, the Midlands and North Wales. This is done via the inclusion of service users as key stakeholders to assist in educating staff on the trauma that restrictive interventions can cause vulnerable patients.

Intervention case study 6. London Safety in Mental Health Settings (SiMHS) project: Implemented across all London mental health trusts, the SiMHS project had an exploratory stage to understand the extent of violence in mental health settings, collect and analyse incident data, conduct in-depth analysis on several serious cases and consult with service users; and an intervention stage which involved implementing several interventions based on feedback from the exploratory stage. The key aspects of this stage were delivering a leadership programme focused on increasing relational security and working towards a trauma informed approach across the trusts.

Post incident measures

Underreporting of incidents of violence, harassment and abuse is a key issue across NHS trusts and organisations. Reporting practices involve several aspects, including the capture and collation of data, which are necessary to provide a clear picture of trends, risk factors, and to predict high risk situations. By having reporting practices in place, trusts and organisations are enabled to begin implementing measures that can help to prevent or mitigate risks. A case study discusses the creation of a data dashboard, a visual representation of real time incident data as well as a predictive tool to demonstrate common trends of violence in the region which has the potential to aid in early intervention work.

Intervention case study 7. A data dashboard for NHS Lancashire and South Cumbria ICS: A data dashboard has been developed by NHS Lancashire and Cumbria ICS to serve as a predictive tool and to demonstrate trends in violent incidents and to provide a visualisation of data from trusts across the ICS footprint.

Encouraging reporting of violent incidents in NHS organisations can have several positive impacts. It can reduce stigma surrounding reporting, boost staff confidence in reporting incidents, and can demonstrate to staff that their management take issues of violence, harassment and abuse seriously. Additionally, collecting comprehensive data from staff reports on all violent incidents can help to understand risk factors, to identify common patient triggers, and to evaluate the effectiveness of existing measures in place. NHS organisations should be aware of challenges that may impact the implementation of reporting practices due to the ingrained cultures of underreporting. After experiencing a violent incident staff may need or want personal support and emotional input from managers. One case study focuses on a pilot of a restorative justice approach in a mental health trust and an ambulance trust.

Intervention case study 8. A restorative justice approach in NHS North East and North Cumbria ICS: A restorative justice approach following any violent or aggressive incidents is being piloted across two trusts (a mental health and an ambulance trust) within the NHS North East and North Cumbria ICS footprint. The intervention also introduces workbooks for line

managers, educating them on the restorative justice and criminal justice systems. The workbooks also provide guidance for ways to support their employees.

Recommendations

Based on the evidence reviewed, violence, harassment and abuse towards staff working in the NHS is best recognised as a complex and multifactorial issue with contributory factors spanning across different levels of the healthcare system as well as beyond the system. There are many causal pathways which are likely to influence the occurrence of violence, harassment and abuse within NHS settings and bringing a systems thinking lens may provide a basis on which to move forward with the development of sustainable organisational responses.

Whole system recommendations (national, regional and local)

1. Building on existing (and future) UK Government and NHS violence prevention policy and governance and practice implementation systems, NHS organisations and ICBs should provide leadership to encourage and support the adoption and implementation of an evidence-based whole system public health approach to violence prevention (covering staff, patients and the wider community across the ICS footprint).
2. NHS England should provide national support and coordination, including guidance and evidence on whole systems approaches to addressing violence, harassment and abuse across healthcare settings, and enable NHS organisations and ICBs to deliver bottom-up flexible approaches to implementation, that is informed by and meets the needs of the local community and setting.
3. NHS organisations and ICBs should explore and evidence the implementation and impacts of the VPR standard, identifying key lessons for implementation and areas for developing the use and value of the standard. NHS England should continue work with NHS organisation and ICBs to roll out the VPR standard.
4. To support the meaningful comparison of local/regional data on violence, harassment and abuse across healthcare settings (and in the ongoing absence of a national data collection system), NHS England should develop guidance for NHS organisations and ICBs including common definitions of violence, harassment and abuse towards NHS staff, standardised methods for data collection and recommended data fields.
5. NHS England should identify opportunities to develop and implement a national system for the collection, analyses and dissemination of data on incidents of violence, harassment and abuse towards NHS staff. The system should enable an increased understanding of the nature and extent of violence, and its consequences, across groups and settings, and risk and protective factors, to inform the development, implementation, and monitoring/evaluation of prevention approaches.
6. NHS England should work with NHS organisations and ICBs to create a culture of rejection and of taking action on violence, harassment and abuse within the NHS, including amongst patients but critically across staff. NHS organisations and ICBs should ensure that experiences of violence are not accepted as part of the job, encourage reporting by

developing and enforcing an open and blame-free culture, and guide staff towards engagement with support services.

7. NHS England, NHS organisations and ICBs should bring the NHS workforce community together and provide support for them to share their experiences of violence and prevention approaches at local, regional and national level (e.g., national conference on violence towards NHS staff).
8. NHS England, NHS organisations and ICBs working with the Unions and through staff networks should ensure that policies and approaches to preventing and responding to violence, harassment and abuse are developed through closer partnership working with representatives across different sectors and groups of the workforce.
9. Working with wider partners, NHS England, NHS organisations and ICBs should develop and/or identify opportunities to robustly evaluate the impact of interventions to prevent and respond to violence against healthcare staff. This may include working with independent evaluators to design evaluation and implementation plans (including logic models/theories of change) for interventions that can/are being implemented at scale (e.g., across healthcare sites/settings) and applying for national research council funding (e.g., National Institute for Health Research) and/or working with partners to identify other research and evaluation funding opportunities (e.g. via local/regional networks/partners such as Violence Reduction Unit's, police, health and social care).
10. Where robust and/or independent evaluation is not feasible or appropriate, NHS systems should work together to develop minimum standards for monitoring and/or evaluation of interventions including guidance around evaluation. This should include consideration of evaluating interventions at different levels e.g. local, regional and systems levels. Reference should also be made to reporting and dissemination of evaluation findings, which may be supported through, for example, communities of practice or workforce research forums to share learning.

Further research recommendations

Fill gaps in current knowledge and evidence identified through this review by carrying out further research, specifically:

- Carry out research to improve understanding of the causes of violence against staff, with specific attention to the staff groups and demographics of those most at risk of violence to design and target appropriate interventions more effectively. Implementation of more robust data collection mechanisms on violence against staff which record occupational and demographics data in incidents of violence against staff and which can be disaggregated to identify at risk groups would support this type of research. This might be done through existing data collection and recording systems such as equality impact assessments or the NHS survey for example.
- Carry out research to enhance understanding of the impacts of violence on NHS staff and staff views on what they require from prevention activity, to ensure approaches keep them safe and healthy.

- Carry out research on, and evaluation of, restrictive interventions in non-mental health settings, particularly emergency departments and within the ambulance service.
- Carry out research to explore formal risk assessment practice across NHS settings to enhance understanding of the role of risk assessment practice and approaches in identifying and anticipating risks that may lead to violence, harassment and abuse towards NHS staff.

1 Background

Violence, harassment and abuse in the workplace is a pervasive global issue with more than one in five people in employment experiencing at least one form of work-based violence during their working life (International Labour Organization (ILO), 2022). Whilst violence can occur in all sectors and affect all categories of workers, some sectors and staff are particularly at risk of exposure to violence, specifically the health sector. International evidence suggests that violence in the health sector may account for almost a quarter of all violence at work (Nordin, 1995), with an estimated 62% of healthcare workers who will be affected by workplace violence in their lifetime (Liu, et al., 2019); almost three times the estimated average prevalence for all workers globally. Concerningly, violence, harassment and abuse against healthcare workers greatly increased during the COVID-19 pandemic, and evidence suggests this upward trend has continued since then (World Health Organization, 2022; Brigo, et al., 2022). Healthcare workers may also experience violence outside of the workplace. A recent review of global evidence suggests that people working in healthcare professions may be more likely to experience domestic abuse than the general population, and that they may feel less able to seek support (Dheensa, et al., 2022).

Violence, harassment and abuse against healthcare workers can have enormous costs for the individual including: physical injuries (Nyberg, et al., 2021); financial implications (Hunter & Carmel, 1992); psychological problems such as PTSD, depressive symptoms, anxiety, burnout, and emotional impacts (e.g. fear, sadness and anger) (Arnetz & Arnetz, 2001; Winstanley & Whittington, 2002; Atawneh, et al., 2003; Atan, et al., 2012; Richter & Berger, 2006); poor work functioning including sick leave, low productivity and low job satisfaction, and quitting the job role (Nolan, et al., 2001; Camerino, et al., 2008; Atan, et al., 2012; Richter & Berger, 2006; Fernandes, et al., 1999); and social consequences such as impact on social life and family relationships (Celik, et al., 2007). Furthermore, the impact of violence against healthcare workers extends beyond the immediate individual and their families, as it is also likely to have a significant impact on the efficiency and efficacy of health systems more widely, impacting the ability to provide high quality patient care. Evidence shows that violence against healthcare workers is associated with lower patient safety and more adverse patient outcomes (Berlanda, et al., 2019).

The enormous impacts and increasing upward trend of violence, harassment and abuse against healthcare workers has drawn the attention of international organisations, policy makers, academics, and the general public. The World Medical Association (WMA) has declared the increase in violence against healthcare workers as a healthcare emergency and called for WHO and member states to take action (The World Medical Association, 2020). Member states, including the UK, are now putting an increased focus on the issue.

1.1 Project background and aims

In 2020/21, the NHS People Plan was published with a strong emphasis on ‘Looking after our People’ – including 23 commitments related to health and wellbeing. One of the NHS People

Plan promises is that all people feel supported, safe, and secure at work. Leaders across the NHS have a statutory duty of care to prevent and control violence in the workplace – in line with existing legislation – so that people never feel fearful or apprehensive about coming to work. Nonetheless, there is clear evidence that violence, harassment and abuse in the workplace is a critical issue across many parts of the NHS, with substantial impacts on individual's health and wellbeing, and the health sector more broadly. However, since NHS Protect was disbanded in 2016, there has been no national NHS-wide data collection of incidents of violence, harassment and abuse towards NHS staff (although data is collected by some sectors, and/or at a local level). This limits opportunities to fully understand the nature, extent and impact of violence, harassment and abuse and its risk and protective factors, which can help inform more effective prevention and response activity. Despite the lack of data collection, the scale of the issue means there continues to be a range of interventions and approaches implemented at local, regional, and national level to address violence, harassment and abuse. Understanding the range of interventions and approaches implemented and how they relate to the undepinning evidence is key to ensuring all people working in the NHS feel supported, safe, and secure at work. Thus in 2022/23, NHS England commissioned the Public Health Institute at Liverpool John Moores University to conduct a review of work-based violence, harassment and abuse towards NHS staff in England.

The overarching aim of the project was to better understand the nature, extent, and impact of work-based violence, harassment and abuse towards NHS staff and to identify good practice in preventative approaches and responses. Specifically, the project aimed to identify evidence about violence, harassment and abuse in NHS settings related to any of the following aspects:

- **Nature** (e.g. types of violence experienced) and **extent** (e.g. numbers of staff impacted, number of incidents);
- **Risk (and protective) factors** (i.e. individual, situational, environmental or organisational factors that increase [or reduce] the risk of violence);
- **Impacts** (e.g. individual impacts such as health and wellbeing, injuries, career, financial and social or organisational impacts such as staff retention, absence, quality of care);
- **Reporting and recording practices** (e.g. how violence is reported, recorded and used to inform prevention and management, or improve working practices); and,
- **Interventions, programmes, projects, policies, frameworks, strategies or tools** (e.g. information on what it is, if it was evaluated/reviewed, any evidence of effectiveness or key lessons on barriers and facilitators to implementation).

1.2 Project methods

This section provides a brief overview of the methods used to achieve the project aims, with the full methodology provided in Appendix 1. Evidence from all methods has been triangulated into the themes presented in the report.

- **Systematic literature review:** Searches were conducted for academic studies related to violence against healthcare staff in the UK published since 2010. References were screened to identify existing evidence regarding (i) factors and processes that

influence work-based violence, harassment and abuse, and (ii) organisational responses to work-based violence, harassment and abuse. Included articles were assessed for quality and evidence extracted about the nature, extent, impact, and prevention/management of work-based violence, harassment and abuse. Additional strategies were used, including targeted searches of Google Scholar and forwards and backwards citation searching to identify further relevant references.

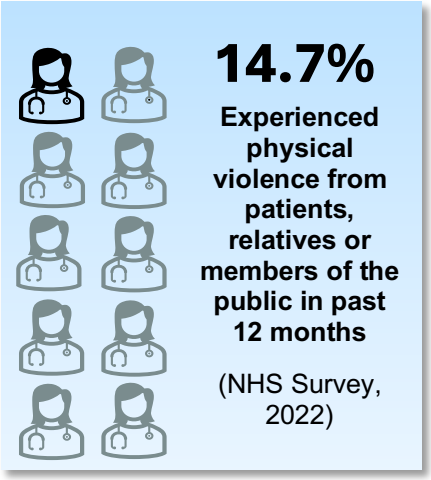
- **Call for evidence:** Stakeholders were invited to submit evidence on (i) the nature, extent, impacts and consequences of violence, harassment and abuse towards NHS staff; and (ii) prevention and management of violence, harassment and abuse, including current and planned system-level or organisational responses.
- **Case study development:** Consultation discussions were conducted with stakeholders who responded via the call for evidence. The purpose was to gather further information about the aims, objectives, and intended outcomes of activities in NHS organisations which are tackling workplace violence, harassment and abuse.

1.3 Definition of workplace violence, harassment and abuse

Workplace violence, harassment and abuse has previously been defined in a number of ways. We recognise the importance of understanding the scope and impact of all acts of violence, harassment and abuse which individuals may experience in the workplace by a wide variety of perpetrators. Therefore, for the purposes of this project, we adopted a broad definition used by the World Health Organization: “the intentional use of power, threatened or actual, against another person or against a group, in work-related circumstances, that either results in or has a high degree of likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation” (World Health Organization, 1995). Throughout this report we use the term ‘violence, harassment and abuse against staff’ to refer to any staff member employed by the NHS who might experience violence, harassment or abuse in any capacity, either by colleagues or by patients, their relatives, or members of the general public.

2 Nature and extent of violence against staff

This section provides an overview of the evidence on the nature and extent of violence against NHS staff. It also includes an overview of the reporting of violence within the NHS. Evidence is drawn from various sources including academic studies, grey literature sources such as the NHS survey data, and organisation and trust incidence data.



2.1 Nature

The nature of violence, harassment and abuse which staff experience is varied and includes a wide range of different types, including physical assault and aggression; verbal aggression, abuse, or threats; sexual abuse, aggression, and assault; discrimination and harassment; and bullying. In addition, staff often witness colleagues experiencing violence, harassment and abuse. Perpetrators include patients, their visitors such as family or friends, members of the general public, and colleagues. Violence, harassment and abuse takes place in a wide variety of settings and across a variety of job roles.

2.1.1 Physical assault and aggression

Physical assault and aggression can be defined as the use of physical force against another person that results in physical, sexual or psychological harm. It can include, amongst others, beating, kicking, slapping, stabbing, shooting, pushing, biting, and pinching (di Martino, 2002).

> *"She head butted me on the side of the head and I … temporarily lost consciousness … literally seconds but I just went blank … she was on top of me and she was biting me. She was scratching my face … head butting me … you're in the back of a car … doing 60 miles an hour … nowhere to pullover safely so this was a prolonged assault." – Community nurse (Lovell & Skellern, 2013)*

Evidence suggests physical assault and aggression is mostly perpetrated by patients, but also by those visiting patients, including family members and friends (Rees, et al., 2015a). A smaller proportion incidents are also perpetrated by other colleagues or supervisors. Some settings and roles have higher rates of physical violence, particularly mental health settings, ambulance staff, and community provision (Royal College of Nursing, 2018).

> *"She [clinical teacher] just flipped her lid and she literally grabbed the walking frame and chucked it across the ward… I just like stepping out of the road because… thought she might hit me with the walking frame." - Student (Rees, et al., 2015a)*

"The person that attacked me was somebody that I'd been very closely involved with … the details stick in your mind … when I turned round he put his hand round my throat, everything was going black …then he let me go, he pushed me away." – Residential care nurse (Lovell & Skellern, 2013)

2.1.2 Verbal aggression, abuse and threats

Verbal aggression and abuse includes behaviours like harsh and insulting language against a person. It can also include threats of physical violence and can include the promised use of physical force or power (i.e. psychological force) resulting in fear of physical, sexual, psychological harm, or other negative consequences to the target individual (di Martino, 2002). Evidence suggests verbal aggression, abuse and threats are a prevalent form of abuse which staff experience (Cooper & Inett, 2018; Knowles, et al., 2013). This can vary in severity, from low-level comments and rudeness, to more severe threats and swearing. It can also include abuse which is sexual in nature (see section 2.1.3) or which is racial and discriminatory (see section 2.1.4). Verbal threats can include intimidating comments such as "we know where you live" (Knowles, et al., 2013).

"I've been punched, kicked, slapped, bitten, spat on, threatened with a knife and a gun. Verbal abuse and threats of sexual violence. Threats to kill me and my family. Threats to rape my children." – Ambulance worker (GMB Union, 2018)

Students in particular reported they were the target of verbal abuse by patients and visitors because of a perceived inability or incompetence to provide care.

"She [patient] was shouting all the odds at me and saying that 'Oh you're so unprofessional how can you not make the veneers." – Dental student (Rees, et al., 2015a)

"I was disrespected on the basis that I am 'below' qualified staff and because I am a student." – Student nurse (Üzar-Özçetin, et al., 2021)

Furthermore, individuals may feel intimidated by verbal aggression even if it is directed at no one in particular, for example patients shouting and swearing about the care received (Knowles, et al., 2013).

*"Someone comes out (of the clinical area) and shouts 'for f**k's sake, what f**k up in here. I've been waiting forever and all they've done is stick a plaster on my finger. I could have done that myself'. Is that verbal aggression? It's not directed at anyone but it certainly feels very intimidating and you just don't know where it's going to go." – ED staff (Knowles, et al., 2013)*

2.1.3 Sexual abuse, harassment and assault

Sexual violence can take many forms including any unwanted, unreciprocated, and unwelcome behaviour of a sexual nature that is offensive to the person involved, and which causes that person to feel threatened, humiliated, or embarrassed (di Martino, 2002). It can

manifest in the form of unwanted or suggestive remarks, as well as more direct and physical forms of sexual abuse and assault, including inappropriate touching.

Evidence suggests staff experience sexual harassment from patients and also fellow colleagues including, unwanted sexual looks or gestures, unwanted deliberate touching, and comments which are sexual in nature (Hallett, et al., 2021; Rees, et al., 2015a).

> *"I have been physically and sexually assaulted by patients on multiple occasions. Recently, an older gentleman alternated between slapping my backside and calling me a stupid bitch/insulting my intelligence because I'm a young woman." – Agency nurse (Royal College of Nursing, 2022)*
>
> *"I had um um an older man patient and he was so inappropriate you know he was saying things like 'oh it's lovely to have two young ladies mucking about in my mouth." – Dental student (Rees, et al., 2015a)*
>
> *"…and like he'd [pharmacist] do things like telling inappropriate jokes but like quite crude jokes… I'd never worked with him before, he didn't know me but obviously I don't have a [names place] accent… and he was like 'where are you from?', '[names hometown]' so then I got like all those kind of really crude [names hometown] girl jokes'." – Pharmacy student (Rees, et al., 2015a)*

2.1.4 Discrimination and harassment

Discrimination and harassment are defined and covered under The Equality Act 2010 and relate to protected characteristics including age, race, sex, gender reassignment, disability, sexual orientation, religion or belief. Discrimination can be in the form of direct discrimination, where an individual is treated less favourably than others because of a protected characteristic, whilst indirect discrimination is where an individual discriminates against another by applying a provision, criterion or practice that is discriminatory in relation to a relevant protected characteristic. Harassment is defined as unwanted conduct related to a relevant protected characteristic or unwanted conduct of a sexual nature. It has the purpose of violating someone's dignity or creating an intimidating, hostile, degrading, humiliating, or offensive environment (HM Government, n.d.).

Discrimination and harassment can be perpetrated by patients, visitors, and members of the public. Evidence shows that staff members from ethnic minority groups are more likely to experience this type of violence than individuals of White ethnicity (see Table 1) (Royal College of Nursing, 2022; Garcha, 2022; Edeh, et al., 2021; The Source, 2022). This often occurs in the form of directed verbal abuse or refusal to be treated.

> *"Being a migrant at work, sometimes you have the patients, you get the awkward patients, and they just yell you I don't want to see you, a foreign doctor, and sometimes some of the elderly patients make comments on your accent, like, oh you sound very foreign, where are you from? Or they are like, oh I can't understand you, you don't speak English." – Nigerian doctor (Edeh, et al., 2021)*
>
> *"Hard at times, underhand comments from staff members about race or jokes." – BAME midwife (Garcha, 2022)*

Evidence also shows that regardless of ethnic background, staff are aware of the commonness of racism (Hallett, et al., 2021).

> *"When a patient is refusing to be seen by a colleague because they're black and they're calling you over, that is so painful to deal with." – London Trust staff (The Source, 2022)*

Evidence suggests discrimination and harassment is also perpetrated by fellow colleagues, managers and supervisors. Some examples of this included direct discrimination by colleagues related to age, ethnicity, sex, level of experience, and a failure of senior staff to support colleagues experiencing discrimination from others (Edeh, et al., 2021; Garcha, 2022; Rees, et al., 2015b; Rees, et al., 2015a; Royal College of Nursing, 2022).

> *"Felt discriminated against and verbally insulted especially in front of the other student nurse as I was the only Asian in the room." – Non-White nursing student (Rees, et al., 2015b)*
>
> *"We were talking about how I'd been treated as though 'you're just a young silly female, what do you know." – Physiotherapy student (Rees, et al., 2015a)*
>
> *"I heard… there's a sort of racial problem there so that really affected me and I was like 'oh I definitely don't want to work with this company'… it was a general thing really 'cause I thought I was the only one experiencing that… there was a time I even got shouted at and the pharmacist was there and he didn't say anything and it was just so upsetting." – Pharmacy student (Rees, et al., 2015a)*

Discrimination and harassment also occur at an organisational level. This can take the form of discrimination regarding job opportunities and career progression, alienation from other colleagues, and a lack of reasonable adjustment for protected characteristics such as disability.

> *"If a White, Caucasian applies for a job, and if a Black sister or brother applies for the same job, you have a duty to make sure you support the Caucasian to get it… even though I score 90 on your scoring sheet and she scores 70, you are going to say, oh 70 is a good score, oh with appropriate support she will get there, you will take her." – Nigerian nurse (Edeh, et al., 2021)*
>
> *"No consideration was given to me by my team members or management for my disability during COVID-19. No workplace adjustments so I had to insist on working from home. For this, I was bullied and harassed by my manager and team colleagues. I have been in dispute with my organisation for 18 months now." – Health visitor (Royal College of Nursing, 2022)*
>
> *"There is a lot of racism in the workplace that is hidden and subtle in the NHS, and it's not always physical nor verbal. It can come in a form of alienation. A lot of nurses in the NHS have a mistrust for foreign trained nurses especially Africans and they feel we are not experienced or knowledgeable enough." – Staff nurse (Royal College of Nursing, 2022)*

2.1.5 Bullying

Bullying can be defined as repeated offensive behaviour through vindictive, cruel, or malicious attempts to humiliate or undermine an individual or groups of employees. Bullying is often covert and out of sight of potential witnesses, and usually escalates over time. Although bullying includes many of the same behaviours and types of violence already discussed, it is also distinguishable in that it is defined by an unequal relationship between the perpetrator and victim. Thus, in the case of workplace violence it is usually perpetrated by managers, supervisors, or teachers against more junior or younger staff and students (Royal College of Nursing, 2022; Rees, et al., 2015a).

"I was verbally abused for being stupid and was humiliated for my mistake. However, I had no bad intent and it was an honest mistake – Student nurse (Üzar-Özçetin, et al., 2021)

"'I was about to sell him [patient] two boxes [medication]. . . then the pharmacist noticed and. . . said 'no you can only sell one sell one packet'. . . I said 'okay I'm sorry I didn't know' and then when the customer left she [pharmacist] said 'don't they teach you at the school?" – Pharmacy student (Rees, et al., 2015a)

"'… 'she would not call me by my name so if I was in with a patient she'd shout 'student nurse''. - Nursing student (Rees, et al., 2015a)

Bullying can also include unfair and discriminatory treatment related to performance (Manolchev & Lewis, 2021; Garcha, 2022; British Medical Association, 2017), the use of humiliating language, tactics and criticism in front of patients (Rees, et al., 2015a; Üzar-Özçetin, et al., 2021), threats of dismissal (Manolchev & Lewis, 2021), and lack of confidentiality around reporting of serious incidents (Manolchev & Lewis, 2021). Bullying can also be perpetuated by organisational cultures of acceptability which encourage and permit bullying. This is particularly the case in organisations which are autocratic and hierarchical, and have target-driven management styles and workload pressures (Manolchev & Lewis, 2021; British Medical Association, 2017).

2.1.6 Witnessing colleagues experiencing violence, harassment and abuse

As well as personal experiences of violence, harassment and abuse, staff can be impacted by witnessing a colleague experiencing abuse. Findings from a 2010 survey (n=2,202) showed that around one quarter (23%) had witnessed an incident of verbal abuse or physical assault on one of their colleagues by a patient or member of the public (Ipsos MORI, 2010). A large-scale 2013 survey of seven NHS organisations representing a variety of trust types including acute care, primary care, and mental health provision (n=2,950) found that over four in ten (43%) staff had witnessed colleagues being bullied at work (Carter, et al., 2013). Findings from a 2018 survey of ambulance staff (n=508) showed that the majority (94%) had witnessed violence against colleagues or were aware of such attacks (GMB Union, 2018).

"I've witnessed people [being bullied], lots of tears, people just behaving badly with other people and not considering other people's feelings, picking on somebody when

they have got a weakness… using quite manipulative behaviour to try and undermine you." (Thompson, et al., 2020)

2.2 Levels of reported incidents of violence

Incidence refers to the number of incidents of violence against staff in a given time period, as opposed to the number of staff experiencing violence. Incidence data is usually collected by an organisation when an individual reports an incident of violence. Thus, it relies on the willingness to report and having sufficient recording and reporting systems and procedures in place.

A Freedom of Information request by the Health Service Journal found that amongst the 181 trusts who provided data, there were over 56,000 reports of physical assaults on staff in 2016/17 averaging a total of 312 assaults per trust (Royal College of Nursing, 2018; Cowper, 2023). Extrapolated to all trusts in England, this equates to 75,000 assaults, with an average of over 200 assaults on staff every day in 2016/17. Levels of violence varied by trust type, with a higher incidence in mental health trusts and medium size organisations. Evidence from a study of incidence data from 127 UK NHS Trusts with A&E departments found that the rate of violence, harassment and abuse[1] towards staff from patients and/or visitors in England was 80 incidents per 100,000 A&E attendances in 2021, with rates of physical violence alone at 23 incidents per 100,000 (see section 2.6.1) (Donald & Lindsay, 2023). For the whole of the UK, there were 156 incidents of sexual abuse in 2021, with a rate of 1.08/100,000 attendances (Donald & Lindsay, 2023). Case study 1 provides the incidence rates for one trust, Liverpool University Foundation Trust, for 2021/22 by nature of violence, harassment and abuse experienced.

Case study 1: Extent and nature of violence in Liverpool University Hospitals NHS Foundation Trust

Liverpool University Hospitals Foundation Trust reported 1,339 violent or abusive incidents against staff via Datix in 2021/22. Split by type of violence experienced, non-physical and physical assaults by patients, relatives, or members of the public were the most common forms of violence which staff reported experiencing.

- 568 incidents of non-physical assault by patients, relatives, or members of the public.
- 68 incidents of non-physical assault by other staff.
- 554 incidents of physical assault by patients, relatives, or members of the public.
- 10 incidents of physical assault by other staff.
- 25 incidents of racial/religious abuse of staff.
- 23 incidents of sexual abuse of staff.
- 91 incidents of written abuse or threats made to staff.

[1] Included any physical assaults resulting in injury and non-injury, verbal abuse, sexual harassment/abuse, and other abuse not falling into these categories.

2.3 Reporting of incidents

Whilst reported incidence data is a key source in understanding the incidence of violence, harassment and abuse against staff, findings from self-report studies show that not all incidences are reported (Stubbs & Soundy, 2013; Stubbs, et al., 2011; NHS England, 2023). Furthermore, willingness to report an incident varies by type of violence experienced, demographic and occupational factors, and a range of contextual factors. In spite of this, evidence from some studies did suggest that reporting had improved in recent years (Lovell & Skellern, 2013).

> *"Probably ten years ago there was quite a bit of under-reporting went on and I think the reporting has developed over time." (Lovell & Skellern, 2013)*

2.3.1 Level of non-reporting

Findings from the 2022 NHS staff survey showed that 50% of staff who experienced some form of harassment, bullying, or abuse in the past 12 months did not report the incident, whilst 28% of those who experienced physical violence did not report the incident (NHS England, 2023). Similarly, a large-scale 2022 study across London NHS organisations showed that 59% of staff did not report their last experience of verbal abuse from patients or visitors (The Source, 2022). Underreporting figures are even higher if data examines the number of staff who do not report every incident, with less than a third of staff reporting every time they'd been subjected to physical abuse, falling to less than a quarter for verbal abuse (The Source, 2022). Reports of bullying may be even lower, with one large 2013 survey across seven NHS organisations (n=2,950) showing that of those who experienced bullying to some degree, only between 3% and 14% reported it, depending on the behaviour and actions that took place (Carter, et al., 2013).

2.3.2 Demographic and occupational factors

A range of factors are associated with staff reluctance to report incidents of violence, harassment and abuse. These include variations in reporting by sociodemographic factors such as age, gender, and ethnicity, qualification level, occupational factors, and type of violence experienced.

Sociodemographic factors including gender, age, and ethnicity have been associated with willingness to report an incident. Findings from the 2022 NHS staff survey suggest proportions of staff reporting physical violence is lowest amongst those identifying as non-binary (63%), compared to males (71%) and females (73%), whilst reporting of harassment, bullying or abuse was lowest amongst non-binary (43%) and males (44%), compared to females (52%) (NHS England, 2023). The same survey also suggests that there is no real age difference in terms of reporting incidents of physical violence, however reporting of harassment, bullying, or abuse decreased as age group increased (Appendix 2; Table A2.1) (NHS England, 2023). Findings from a large 2022 survey (n=1,391) across 30 London NHS organisations showed that staff from ethnic minority groups were generally more likely to report incidents of verbal

and physical violence by patients or visitors, compared to those of White ethnicity (The Source, 2022).

Trainees and students have been found in several studies to have high levels of non-reporting of incidents of violence or bullying experienced whilst on placement. A study of nursing students found that only around a third of non-physical aggression and about half of physical aggression and sexual harassment was reported (Hallett, et al., 2021). Two small studies done with physiotherapy students found that the majority (84%, n=52) did not report incidents of bullying during their clinical placement (Stubbs & Soundy, 2013), or incidents of violent and aggressive behaviour from patients (100%; n=64) (Stubbs, et al., 2011). One report based on the 2016 NHS staff survey found that amongst doctors and dentists, trainees were the least likely to report incidents of harassment, bullying and abuse. (British Medical Association, 2017).

Occupational factors such as occupation group, trust type, length of service, and amount of patient contact also demonstrate variations in levels of reporting (NHS England, 2023). Findings from the 2022 NHS staff survey suggest proportions of staff reporting physical violence is lowest amongst those in medical and dental occupations (53%), with the highest proportion of reporting amongst registered nurses and midwives (84%; Appendix 2; Table A2.1). Similarly, proportions of staff reporting harassment, bullying and abuse was lowest amongst those in medical and dental occupations (32%) however, the highest proportion of harassment, bullying, and abuse reporting was amongst nursing and healthcare assistants (60%; Appendix 2; Table A2.1).

By trust type, the lowest levels of reporting of any type of violence was in acute trusts and acute community settings (physical violence, 68%; harassment, bullying, or abuse, 47%), whilst the highest rates of reporting were in ambulance trusts (physical violence, 89%; harassment, bullying, or abuse, 60%; Appendix 2; Table A2.1).

In terms of length of service, the lowest proportion of those reporting physical violence was amongst those who were there less than 1 year (67%), compared to those with a longer length of service in the NHS (>72%) (Appendix 2; Table A2.1). Further, for reporting of harassment, bullying, or abuse, those with the longest service (>15 years) had the highest levels of reporting (48%), with reporting levels decreasing as years of service decreased (Appendix 2; Table A2.1).

Considering staff in patient facing roles, for both physical violence and harassment, bullying, or abuse, those with no patient contact had the lowest rate of reporting, compared to those with frequent or occasional contact (Appendix 2; Table A2.1).

The type of violence experienced seems to have a significant impact on the likelihood of reporting. Violence perceived as ‘less serious’ such as harassment, bullying, or abuse is reported far less than incidents of physical violence. Furthermore, incidents of physical violence which result in injury are more likely to be reported than those that don’t. This suggests the perceived ‘seriousness’ of the incidence influences the degree to which it is likely to be reported.

2.3.3 Reasons for non-reporting

Evidence suggests there are several reasons that violence, harassment and abuse are not reported. These include the acceptability of violence and a perception of inevitability among staff, the perception that even if reported no further action will be taken, a feeling of personal responsibility and skill inadequacy which may have contributed to the occurrence of the incident, and the burden involved in reporting an incident.

Inevitability and acceptance of violence was a common finding in the evidence, and this was also often given as a reason for non-reporting of incidents (Cooper & Inett, 2018; Ashton, et al., 2018; Knowles, et al., 2013; Lovell, et al., 2011). This was particularly the case in certain settings such as A&E and acute mental health settings. Acceptance of violence was particularly evident where patients are perceived to have less capacity to reason or had a mental illness or psychiatric disorder (Cooper & Inett, 2018; GMB Union, 2018; The Source, 2022). Trainees and students were also more likely to accept violence (Üzar-Özçetin, et al., 2021; Hallett, et al., 2021). Critically, evidence suggests this acceptance and perceived inevitability of violence in some settings and by some groups is influenced by overall workplace culture (Üzar-Özçetin, et al., 2021; Tee, et al., 2016).

There is a reluctance to initiate proceedings against assailants with a mental health condition when, due to cutbacks, there is often no alternative provision within the NHS (GMB Union, 2018). This means that action is not always taken against violent individuals who continue to represent a recurring danger for staff members (GMB Union, 2018; Royal College of Nursing, 2022; Snook & NHS England, 2023). Evidence also suggests that police are less likely to act on reports of violence if the perpetrator has poor mental health (Royal College of Nursing, 2018; Snook & NHS England, 2023).

> *"It's become an accepted part of the job. On a daily basis nurses are subjected to more and more abuse from patients/relatives, we report this but nothing changes. It's become culturally acceptable within Mental Health and Learning Disabilities." – Nurse working on a mental health ward. (Royal College of Nursing, 2022)*
>
> *"Umm, I also didn't realise at the time, that I was supposed to go and report these little things because… I know it sounds silly, but you become sensitized to things." – Staff member working in an NHS low-secure forensic service (Cooper & Inett, 2018)*

Another reason for non-reporting may be the perception that nothing will be done about it (Hallett, et al., 2021; Knowles, et al., 2013; Carter, et al., 2013; Lovell, et al., 2011; The Source, 2022; Rivett & Wood, 2023; Hunter, et al., 2022; Manolchev & Lewis, 2021). Findings from a large 2013 survey across seven NHS Trusts (n=2,950) found that there was a perception that bullying was part of the workplace culture and that reporting bullying in particular, had the potential to have you labelled as a trouble maker (Carter, et al., 2013). Findings from a large-scale 2022 survey of staff (n=1,391) from more than 30 NHS London organisations showed that one third of staff felt that their employer didn't take their reports of violence, aggression, and abuse from patients or visitors seriously (The Source, 2022). Findings from the 2017 Royal College of Nursing Survey (n=6,204) found that of over 4,000 nurses who had

experienced verbal abuse, less than half reported it (47%), and of those who did report it only 56% were satisfied with the outcome of reporting the incident (Royal College of Nursing, 2018).

> *"…[I submitted an incident on] Datix [NHS risk reporting system]. Nothing came out of it. Nothing was done. Nobody approached me. I just had to deal with it myself. So that was it." – Staff member working in an NHS adult acute mental health inpatient hospital (Rivett & Wood, 2023)*
>
> *"They might have been involved in lots of incidents and report it to the police, but nothing happens, staff get a bit disgruntled that don't think anything happens with report." – Staff member working in a mental health trust (Snook & NHS England, 2023)*
>
> *"Because I had put myself in that situation, it was kind of like, it was your own fault, you silly devil, it's daft isn't it. I didn't want to report it… I felt stupid really… I should have known better." – Community nurse working in the learning disability directorate of an NHS trust (Lovell & Skellern, 2013)*

Some evidence suggests that underreporting may also be a result of the perceived work involved in completing incident forms (Knowles, et al., 2013; Lovell, et al., 2011).

> *"As nurses we spend 80% of our time filling in forms, last thing we want is another form to fill in." – Staff member working in an NHS Emergency Department in the North of England (Knowles, et al., 2013)*

2.4 Proportions of staff affected by violence, harassment and abuse

Due to issues with reporting, self-report data from surveys is an important way of measuring the extent of violence, harassment and abuse against staff as it does not rely on the incident having been formally reported and recorded. One of the largest and best sources of self-report data is the annual NHS survey conducted since 2003 (NHS England, 2023). The 2022 survey included 215 trusts and found that the most prevalent forms of violence were perpetrated by patients, their relatives, or members of the general public, with one in seven (14.7%) staff experiencing physical violence and almost one third (27.8%) experiencing harassment, bullying or abuse (NHS England, 2023). Findings from other large surveys of NHS staff include:

- In a 2009 study of frontline NHS staff, 37% had experienced verbal abuse or threats and/or physical assault by a patient or member of the public (Ipsos MORI, 2010). One in ten (11%) had experienced harassment, bullying or abuse from managers, whilst almost one in five had experienced this from other colleagues. Less than 2% had experienced physical violence from managers (0.8%) or other colleagues (1.8%).
- In a large 2013 survey across seven NHS organisations representing a variety of trust types including acute care, primary care, and mental health provision (n=2,950), one

in five (20%) staff members had been bullied in the last six months, with the most common perpetrator being a supervisor or manager (Carter, et al., 2013).

- In a large 2022 survey of staff (n=1,391) from more than 30 NHS London organisations, the majority of staff (86%) had experienced verbal abuse from patients or visitors during their careers, whilst four in ten (39%) had experienced physical abuse (The Source, 2022).

Table 1 provides an overview of evidence across other smaller studies, or studies of specific staff groups on proportions of staff experiencing violence.

"He broke my arm there and then of course my arm went into all sorts of nervous spasms and there was blood everywhere and… he got a pool cue… and he was hitting me with that as well." – Forensic community nurse working in the learning disability directorate of an NHS trust (Lovell & Skellern, 2013)

Table 1: Prevalence of violence across studies, by setting/job role and nature of violence

Author(s), year	Setting/job role	Sample size	Perpetrator(s)	Physical	Verbal	Sexual	Discrimination & harassment	Bullying	Witnessing violence	Any violence or abuse
(Elston & Gabe, 2016)	GPs in NHS South Thames region	697	Patient	13% of males[2] 7% of females	74% of males[2] 78% of females	1%[2]				78%[2]
(Lepping, et al., 2013)	High-risk acute medical wards North Wales	158	Patient, visitor, colleague	63%[3]	83% verbal aggression[3] 50% threatened			8%		
(Royal College of Nursing, 2022)	UK Nurses	9,556	Patient, service user or relative	26%[4]	64%[4]		Verbal abuse[4,5] Asian 62.2% Black 71.2% Mixed 34.2% White 5.4% Physical abuse[4,6] Asian 55.8% Black 62.9% Mixed 34.3% White 4.7%	34%[4]		
(Hallett, et al., 2021)	Nursing students	129	Patient, visitor, colleague	56%	81%[7]	39.5%				
(Hunter, et al., 2022)	Nursing students	138	Patient, visitor		77%					
(Tee, et al., 2016)	Nursing students	657	Patient, visitor, colleague	~23%[8]	28%		9% racism 12% sexism 12% classism 9% sexuality	42%	30%	
(Deery, et al., 2011)	Nurses in London NHS hospital trusts	2,221	Patient, visitor, colleague		34%					
(Stubbs & Soundy, 2013)	Physiotherapy students	52	Patient, visitor, colleague					25%		
(Stubbs, et al., 2011)	Physiotherapy students	64	Patient, visitor, colleague							52%

[2] Past two years.
[3] Past four weeks.
[4] Past 12 months.
[5] Of those who experienced verbal abuse.
[6] Of those who experienced physical abuse.
[7] Non-physical aggression including bullying.
[8] Depending on type of physical abuse.

Author(s), year	Setting/job role	Sample size	Perpetrator(s)	Physical	Verbal	Sexual	Discrimination & harassment	Bullying	Witnessing violence	Any violence or abuse
(Manolchev & Lewis, 2021)	Employees in 2 Ambulance trusts	trust 1: 1,035 trust 2: 2,093	Colleague					trust 1: 25% trust 2: 42%		
(Lovell, et al., 2011)	Nurses in learning disability service	164	Service users		75%					
(Garcha, 2022)	BAME midwives in Coventry and Warwickshire hospitals	17	Patient, visitor, colleague				94% patients, relatives, public 65% staff 41% managers, team leaders or colleagues			
(General Medical Council, 2022)	Trainee doctors in UK	48,785	Colleague				12%[9]			
(GMB Union, 2018)	Ambulance workers in UK	504	Patient	72%[10]					94%[10]	
(GMC, 2014)	Trainee doctors in UK	49,883	Colleague					8%		

Note: Percentages have been rounded to the nearest whole number. Studies are not directly comparable as they use different years of study, different measures of violence, different time periods of exposure (e.g. past year, past four weeks), and different perpetrator(s).

[9] Percentage who do not agree that their employer provides a supportive environment for everyone regardless of background, beliefs, or identity.
[10] Ever whilst working in ambulance services.

2.5 Frequency of violence, harassment and abuse

Evidence shows that violence, harassment and abuse occurr frequently. This is particularly the case for verbal abuse and violence, and abuse perpetrated by patients, relatives, and members of the public.

Findings from the 2022 NHS staff survey showed that of those who had experienced physical violence, 5.7% experienced three or more incidents of violence perpetrated by patients, relatives, or members of the public, whilst 1.4% experienced more than 10 incidents (Table 2) (NHS England, 2023). Of those who had experienced harassment, bullying, or abuse, 11.5% experienced three or more incidents of violence perpetrated by patients, relatives, or members of the public, whilst 3.4% experienced more than 10 incidents (Table 2). These findings are considerably lower than other studies. For example, findings from a 2009 study of frontline NHS staff, found that of staff who had experienced abuse by patients or members of the public, 42% experienced verbal abuse on two to five occasions, whilst 34% had experienced physical assault on two to five occasions (Ipsos MORI, 2010). A large representative survey of staff (n=1,391) from more than 30 NHS London organisations found over one in three (37%) had experienced physical abuse from patients or visitors on five or more occasions, whilst verbal abuse was far more frequent with over half (52%) experiencing it on more than 10 occasions (The Source, 2022).

> *"If we're counting being shouted at or called names, told to 'fuck off' as abuse, then it's every day, obviously there are nice people too, nice patients, but everyday there's someone who thinks it's acceptable to scream at you, tell you you're 'shit'." – Staff member working for NHS London (The Source, 2022)*

Table 2: Frequency (%) of violence experienced by NHS staff, by perpetrator and violence type. Source: NHS Staff Survey 2022.

	Physical violence			Harassment, bullying, or abuse		
	Patients, relatives, members of public	Manager	Other colleagues	Patients, relatives, members of public	Manager	Other colleagues
Never	85.3	99.2	98.2	72.2	88.9	81.3
1-2	9.0	0.5	1.3	16.1	7.2	13.0
3-5	3.2	0.1	0.3	6.1	2.2	3.4
6-10	1.1	0.1	0.1	2.2	0.8	1.1
>10	1.4	0.1	0.1	3.4	1.0	1.2

2.6 Trends in violence, harassment and abuse

Levels of violence, harassment and abuse against staff may change over time and during particular periods, for example during the COVID-19 pandemic. This section provides incidence and prevalence data to show how levels of violence have changed in recent years, including during the COVID-19 peak period.

2.6.1 Temporal trends

Incidence data from 127 NHS Trusts in England with A&E departments found the rate of violence, harassment and abuse[11] towards staff from patients and visitors rose from 56 incidents per 100,000 A&E attendances in 2017 to 80 incidents per 100,000 in 2021. This represents an increase of 43% over five years (Donald & Lindsay, 2023). The biggest yearly change was recorded from 2019/20, with the incident rate increasing from 63 per 100,000 to 82 per 100,000. Analysis also shows that there is regional variation in these changes in incidents rates. Large increases were observed in five regions, including the South East (60%), London (78%), the North East and Yorkshire (83%), the North West (112%) and the South West (23%). Small decreases were observed in the Midlands (-17%) and East of England (-6%) (Figure 1). A subgroup analysis examining physical violence found the rate rose from 18 incidents per 100,00 A&E attendances in 2017 to 23/100,000 in 2021, an increase of 26% over five years (Donald & Lindsay, 2023). The biggest yearly change was recorded in 2019-2020, incidence increased from 20 per 100,000 to 26 per 100,000. Analysis also showed regional variation in changes in incidents of physical violence. Large increases observed in three regions including London (38%), the North East and Yorkshire (72%) and the North West (174%). Small decreases were observed in the Midlands (-10%) and East of England (-4%) (Figure 2).

Other examples of temporal trends include:

- Case study 2 provides the incidence rates for Leeds Teaching Hospitals NHS Trust by perpetrator and violence type, showing an increase in incidence between 2020-2022. Similarly, rates of reported physical assaults against ambulance workers also increased each year between 2012 and 2018 (Figure 3 and Figures A2.2). Rates of sexual assault also increased by 211% between 2012/13 and 2016/17 (GMB Union, 2018).
- Whilst data shows an increase in incidence in recent years, prevalence data from the self-report NHS Staff Survey suggests that levels of harassment, bullying or abuse, and physical violence, either remained approximately stable or decreased across a five-year period between 2018 and 2022 (Figure 4 and 5) (NHS England, 2023).
- Findings from a 2022 survey of staff (n=1,391) from over 30 NHS organisations in London, showed that 55% of staff feel that issues of violence, aggression and abuse from patients or visitors feel like the worst they've ever been (The Source, 2022). Findings from a 2018 survey of staff employed by ambulance trusts showed that 80% agreed that the risk of violent assault had an increased in the previous five years (GMB Union, 2018).

[11]Included any physical assaults resulting in injury and non-injury, verbal abuse, sexual harassment/abuse, and other abuse not falling into these categories.

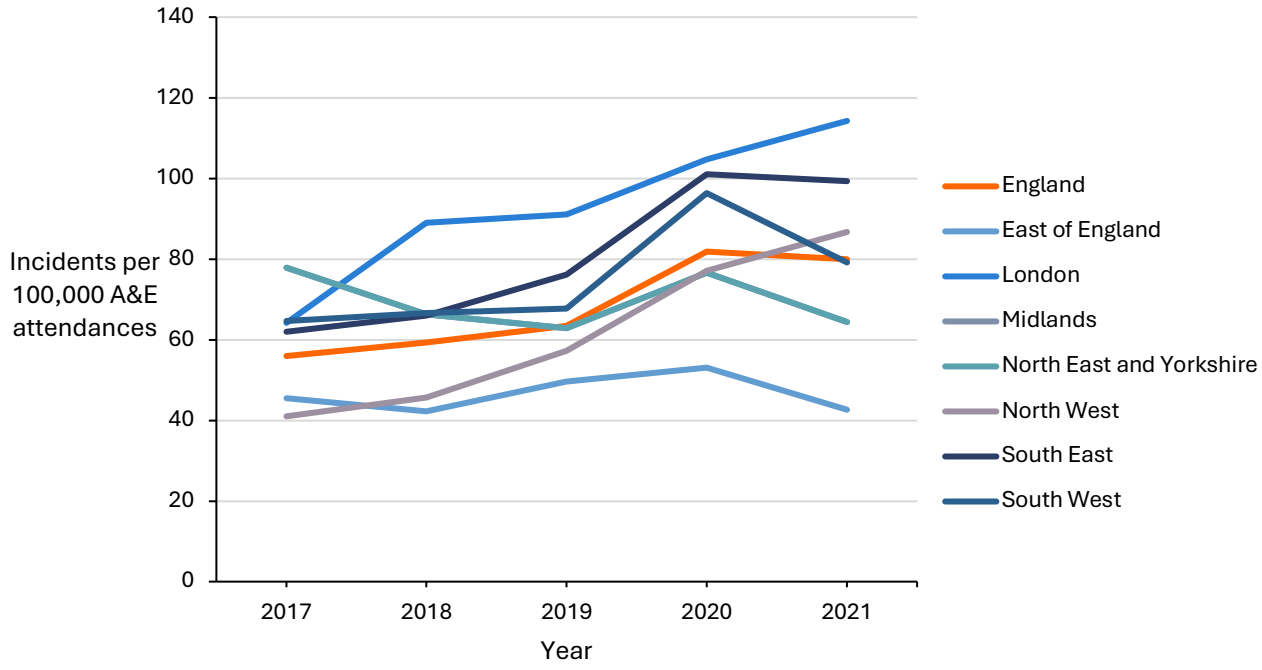
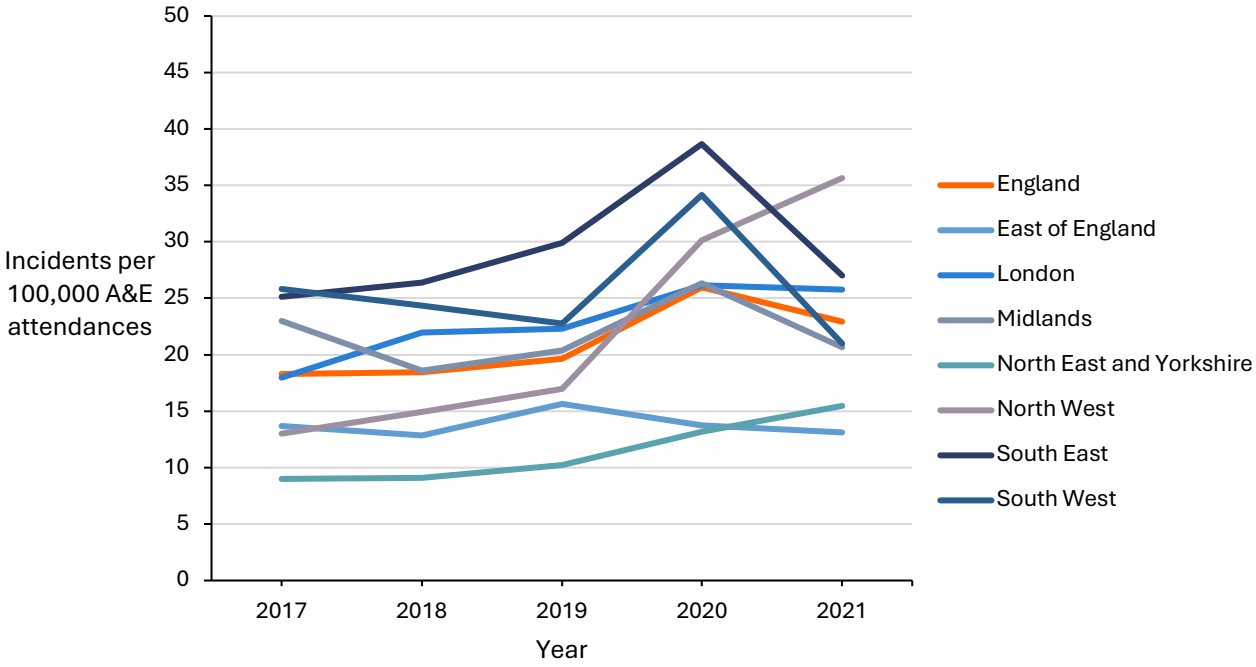


Figure 1: Patient/visitor violence, harassment and abuse against staff in Emergency Departments in England, by year and region. Source: Donald & Lindsay, 2023.

Figure 2: Patient/visitor physical violence against staff in Emergency Departments in England, by year



and region. Source: Donald & Lindsay, 2023.

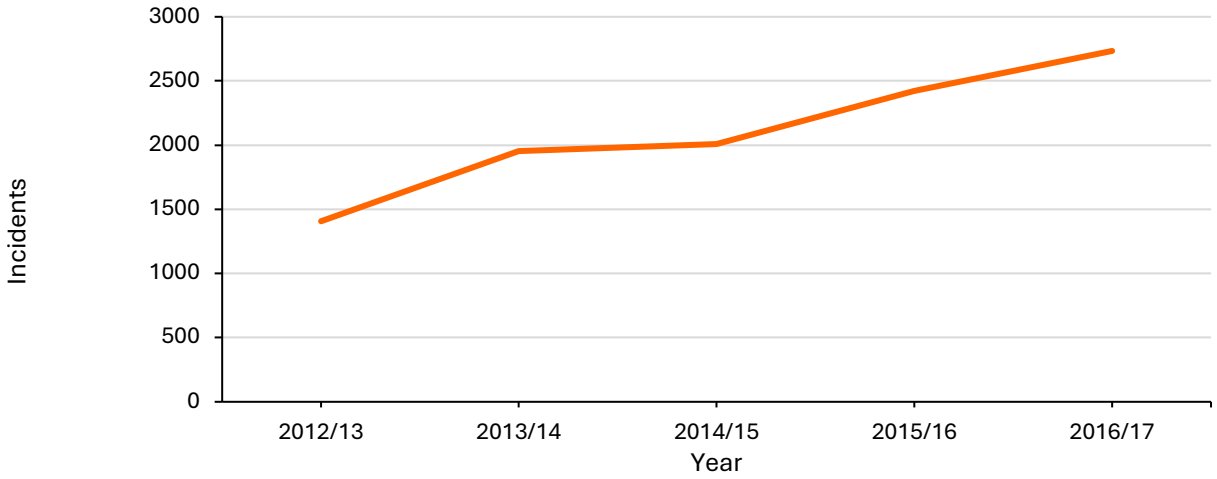


Figure 3: Physical assaults against ambulance workers in England, by year. Source: GMB Union, 2018.

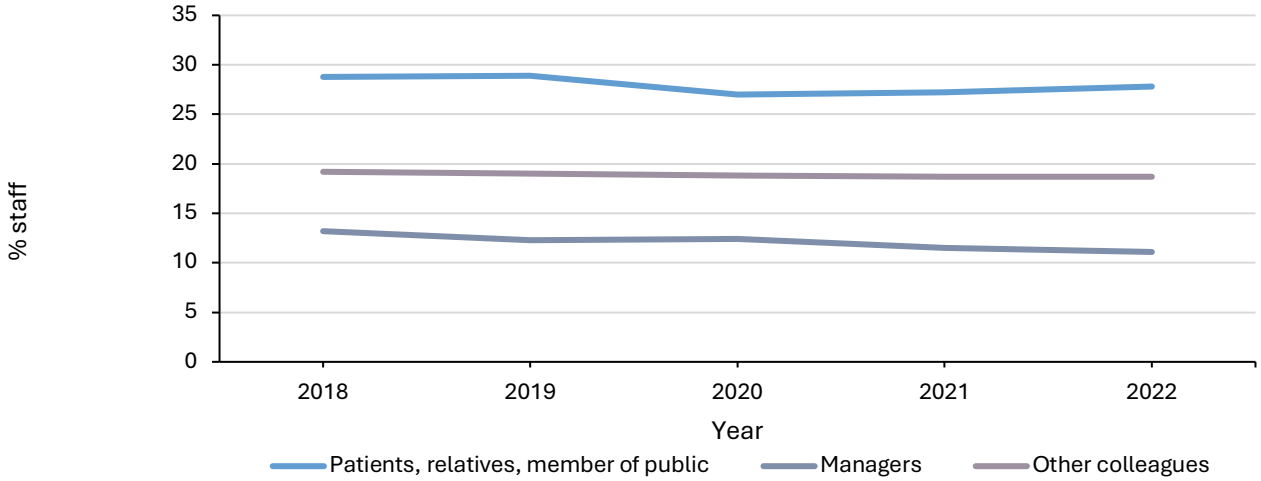


Figure 4: Harassment, bullying and abuse against staff, by year and perpetrator. Source: NHS Staff Survey 2022.

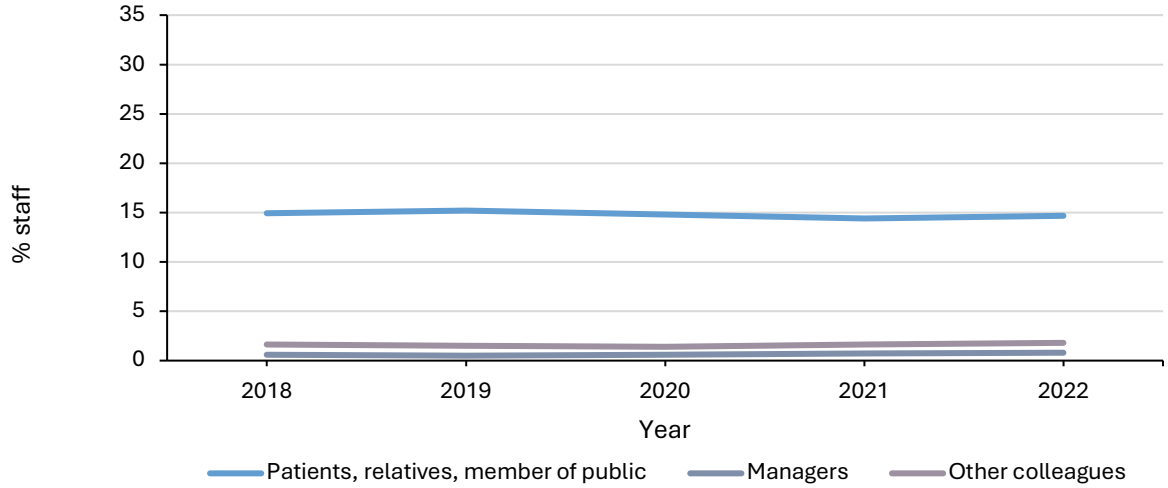


Figure 5: Physical violence against staff, by year and perpetrator. Source: NHS Staff Survey 2022.

Case study 2: Temporal trends of violence in one trust, by perpetrator and violence type within Leeds Teaching Hospitals NHS Trust

Leeds Teaching Hospitals NHS Trust reported 273 violent or abusive incidents against staff via Datix in 2020, 637 incidents in 2021, and 605 incidents in 2022. Across all three years the highest number of assaults experienced by staff were physical in nature and perpetrated by patients with no capacity/medical reasons, however there were significant increases in these incidents recorded in 2021 and 2022, compared to 2020. Similarly physical assaults by patients with capacity were higher in 2021 and 2022, compared to 2020. Levels of visitor assault and staff-on-staff assault were relatively low each year but still saw increases in incidence in 2021 and 2022 compared to 2020. Patient non-physical assault showed a small decrease in 2022, compared to 2021 and 2020.

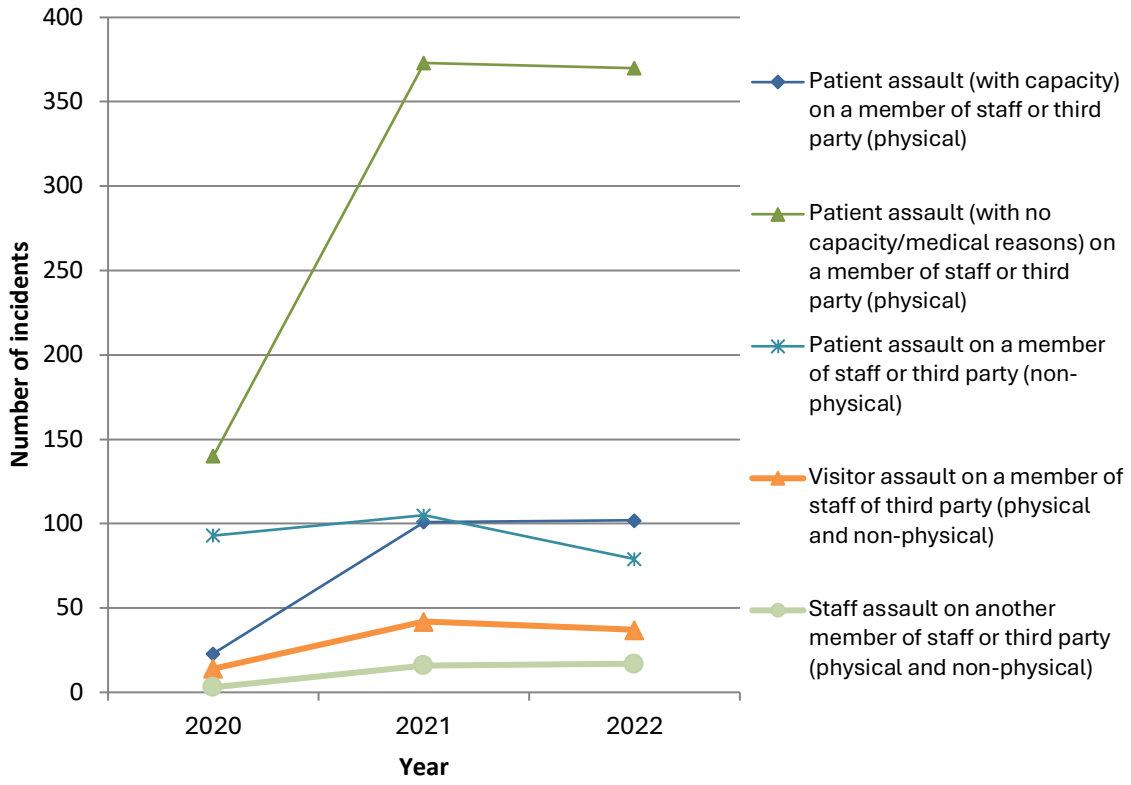


Figure 6: Violence against staff incidence data 2020-2022, by perpetrator and violence type. Source: Leeds Teaching Hospitals NHS Trust.

Note: Due to small numbers, visitor physical and non-physical assaults, and staff physical and non-physical assaults were combined. Data on patient capacity for incidents of non-physical assault was not available.

2.6.2 Impact of COVID-19

A study done in 75 NHS Trusts with A&E departments examined the impact of the government mandated lockdowns during the pandemic. A statistically significant increase in incidents of workplace violence, was observed from January 2017 to March 2020. After the government mandated lockdowns were implemented in March 2020, incidents continued to increase significantly, by 5.06 incidents of violence against staff per 100,000 A&E attendances and remained high throughout the lockdown period. This equated to an approximate 50% rise in

work-related violence over a two-year period. Overall, the study concluded that the level of violence, harassment and abuse against staff was higher than pre-lockdown levels and far higher than the levels observed in 2017 (Donald & Lindsay, 2023).

A large representative survey of staff (n=1,391) from more than 30 NHS London organisations found that almost seven in ten staff (67%) had experienced an increase in violence, harassment and abuse since the pandemic began, with over half (55%) reporting that it was "the worst it had ever been" (The Source, 2022). Younger staff, females, those working in primary care and in departments such as A&E appeared to be more likely to report an increase in experiences of violence, harassment and abuse since the COVID-19 pandemic (The Source, 2022).

Evidence from a study of adult acute wards and psychiatric intensive care units in South London found a 35% increase in incidents of violence, harassment and abuse during the COVID-19 restrictions between March and June 2020[12] (Payne-Gill, et al., 2021).

> *"It didn't take long, yes there was clapping and maybe people were a bit more considerate in the first few months, that didn't last though, it's been bad for a long time, people don't accept that we are still exhausted, still struggling though this." (The Source, 2022)*

[12] Includes all incidents of violence and aggression, not limited to violence against staff, and also includes damage to property.

3 Impacts of violence against staff

3.1 Individual impacts

Research demonstrates the significant and substantial impacts violence, harassment and abuse has on staff at an individual level. This can include severe impacts on mental and physical health, and occupational related impacts such as poor job satisfaction. Furthermore, cultures that tolerate and normalise violence across the healthcare sector can lead staff to view exposure to violence as an inherent part of the job.

£2.3 billion

Estimated financial cost of bullying and harassment to NHS England (Kline & Lewis, 2019)

3.1.1 Mental health problems

Evidence suggests violence, harassment and abuse can impact mental wellbeing and may lead to the onset of more severe psychiatric disorders such as post-traumatic-stress disorder (PTSD) and other disorders (Ipsos MORI, 2010). Evidence shows that immediately after incidents of violence, staff feel "shaken up", "drained", "anxious", "helpless", "frightened and scared", and "stressed" (Cooper & Inett, 2018; Üzar-Özçetin, et al., 2021; Farley, et al., 2015; Jeffrey & Fuller, 2016; Deery, et al., 2011; The Source, 2022). Evidence also shows that violence, harassment and abuse impacts on individuals' confidence in their ability to perform their role and feelings of inadequacy (Hunter & Carmel, 1992; Tee, et al., 2016). Witnessing abuse of colleagues can also have significant impacts on individuals' mental health (Thompson, et al., 2020).

> *"It was [a physical violence] incident which I was very stressed about and … it affected me quite a lot. For a few days I couldn't even sleep properly." (Rivett & Wood, 2023)*

A study of staff in public facing roles (e.g. including doctors, nurses, porters, community staff, dentists) across England (n=2,202) found that one in four staff reported experiencing emotional and/or psychological distress following an incident of verbal abuse (25%) or physical assault (27%) (Ipsos MORI, 2010). Witnessing abuse of colleagues can also impact mental wellbeing. For example, 43% of doctors (n=900) who had witnessed verbal or physical abuse from patients or their relatives in the previous 12 months said it had a significant or moderate impact on their mental wellbeing (Medical Protection Society, 2023). A study of general practitioners found that experiences of violence, harassment and abuse can also challenge perceptions of self and assumptions about masculine strength and control (Elston & Gabe, 2016).

> *"I think that's one of the reasons why it [assault] affected me as much as it did, in that, um, I'd been a sportsman, I was fairly, you know, physically active, felt that I was, you know, stronger than average, didn't really feel threatened. I mean, I had travelled all over the world with not ever being threatened. Um, it was the first time I'd ever been*

beaten in a fight since I was at school, and I always had the physical self-confidence which was then very threatened. It suddenly made me feel very old, you know. Um . . . it's just, you know, aware of your vulnerability." – General Practitioner (Elston & Gabe, 2016)

Evidence shows bullying and harassment from colleagues can also have significant impacts on mental and psychological wellbeing (Stubbs & Soundy, 2013; Tee, et al., 2016; Carter, et al., 2013; Burnes & Pope, 2007). One national study of nurses found that the impacts of bullying and harassment by colleagues can be more significant for mental health than violence and abuse from patients and other members of the public (Woodrow & Guest, 2012). A large study (n=2,950) across seven NHS Trusts found that of staff who had experienced violence, 30% scored high on a measure of symptoms of psychological distress (Carter, et al., 2013). Furthermore, bullying can impact feelings of safety at work, with one study of nurse trainees (n=657) finding that around half felt fearful (54%) and unsafe at work (43%) due to bullying (Tee, et al., 2016). In particular, discrimination and harassment related to protected characteristics can significantly impact mental health (Gafson, et al., 2017; Garcha, 2022).

"Constant hitting the visible and invisible walls of discrimination and prejudice – tired of running the extra five miles to be on par with White British trainees, seeing the injustice in training." – Obstetrics and gynaecology trainee (Gafson, et al., 2017)

Critically, where bullying and harassment is tolerated and not challenged, this can create cultures of bullying which undermine job performance and significantly impact staff mental and psychological health (Gafson, et al., 2017; Üzar-Özçetin, et al., 2021; Whiteside, et al., 2014).

3.1.2 Physical health problems

There is limited evidence about the physical health impacts of experiencing violence, harassment and abuse, but studies do suggest that incidents of physical violence can leave individuals with physical injuries and symptoms that can have devastating impacts on both their career and personal lives (Carter, et al., 2013). One study of staff working within 31 psychiatric wards across 15 London hospitals, found that staff who had experienced physical violence in the past year exhibited significantly poorer physical health compared to those who had not experienced such incidents (Renwick, et al., 2019). A national campaign #Workwithoutfear highlighted a widely discussed and prominent media case of an incident where two paramedics were stabbed while on duty. One of the paramedics sustained a chest stab wound and required ongoing physiotherapy due to her injuries and experienced persistent physical pain, as well as significant mental health challenges following the incident (Northwest Ambulance Service, 2022).

"Affected me physically ... symptoms which I realise now [were] psychosomatic because of the stress you were under and they've gone away since I came away from that." – NHS staff member working in the North East of England (Carter, et al., 2013)

3.1.3 Low job satisfaction

Violence, harassment and abuse have been shown to have significant impacts on job satisfaction, morale, and can lead staff to reconsider their future with the NHS (The Source, 2022; British Medical Association, 2017; Üzar-Özçetin, et al., 2021; Carter, et al., 2013; Farley, et al., 2015; Totman, et al., 2011). A large survey of staff (n=1,391) from more than 30 NHS London organisations found that a significantly higher proportion of staff who did not have experiences of violence, harassment abuse were enthusiastic about their job, looked forward to going to work, and were satisfied with their job (The Source, 2022). Studies of trainee doctors and student nurses have also found that those who experienced violence, harassment and abuse may have low job satisfaction and reconsider their career in the NHS (Üzar-Özçetin, et al., 2021; Farley, et al., 2015).

> *"Threatened with placement fail grade for requesting a Saturday off after working four weekends." – Nursing student (Üzar-Özçetin, et al., 2021)*

3.1.4 Increased acceptability of violence

Evidence suggests that violence, harassment and abuse are often accepted and normalised as part of the job (Sunley, 2018; Binmadi & Alblowi, 2019; Hunter, et al., 2022; Rivett & Wood, 2023). Acceptability can be perpetuated by cultures that normalise and tolerate violence, harassment and abuse with some studies finding that staff were often advised to *"just get on with it"* leading them to emotionally disconnect and desensitize themselves from such incidents in order to continue their work (Rivett & Wood, 2023; Hunter, et al., 2022). Tolerance, acceptance and normalisation of experiences of violence can also impact on levels of reporting especially when staff feel there is an expectation to accept such behaviour (Hunter, et al., 2022; Üzar-Özçetin, et al., 2021). For example, a study of nursing students found they refrained from reporting incidents of violence due to feelings of embarrassment, self-blame, a desire to avoid appearing overly sensitive, a reluctance to create trouble, or the expectation to endure such situations (Hunter, et al., 2022).

> *"I think sometimes students don't complain as it just seems to be an accepted part of being a student and the way people are within the healthcare environment." – Nursing student (Üzar-Özçetin, et al., 2021)*

3.1.5 Worsening career progression or prospects

Evidence shows that staff often feel unsupported by their manager after experiencing violence, harassment and abuse and that this can have a greater negative impact than the incident itself (Rivett & Wood, 2023; Cooper & Inett, 2018; Hislop & Melby, 2003; Knowles, et al., 2013; Manolchev & Lewis, 2021).

> *"But it wasn't actually the incident, it was the aftermath of it. […] it was the way I was treated, and the way I was made to feel, it was all my fault." – Staff member working in an NHS low-secure forensic service (Cooper & Inett, 2018)*

Evidence suggest that in some instances, managers and senior staff may be perceived as penalising staff for reporting violence, harassment and abuse in the form of hindering career progression. For example, a study of ambulance staff found that participants believed reporting instances of bullying and harassment (especially incidents involving higher-ranking staff) would be futile due to an apparent tendency among managers to protect one another rather than addressing the issues seriously (Manolchev & Lewis, 2021). This study also found that participants believed reporting issues could negatively impact on career progression. Similarly, three studies found that students and trainees felt that when they expressed concerns of bullying and undermining to educational leads or clinical supervisors their concerns were disregarded or negatively affected their academic or work progress (Gafson, et al., 2017; Whiteside, et al., 2014; Birks, et al., 2017).

> *"Often students feel that they cannot raise concerns as that means they then get lower grades from the mentor." – Nursing student (Birks, et al., 2017)*
>
> *"Bad experience in a department notorious for bullying, which is raised year after year on the [General Medical Council] survey and nothing changes!" – Obstetrics and gynaecology trainee (Gafson, et al., 2017)*

3.2 Organisational impacts

In addition to individual level impacts, violence, harassment and abuse against staff has serious implications at an organisational and system level, including increases in staff absence, poor staff retention, reduced patient quality of care, and associated financial costs.

3.2.1 Staff sickness absence

Evidence suggests that experiencing violence, harassment and abuse can result in staff needing substantial time off work due to physical or psychological trauma. One study of nursing students found one in ten (10%) called in absent after an incident of bullying and harassment (Tee, et al., 2016) and a study of ambulance staff found that 21% had taken sick leave following a violent assault (GMB Union, 2018). Staff absenteeism has financial impacts for organisations and puts pressure on the system. Reduced staffing levels increase the risk of burnout for other staff membersas well as treatment waiting times (Burnes & Pope, 2007; Rivett & Wood, 2023; Carter, et al., 2013; Irwin, et al., 2013). In a national survey of UK doctors, nearly half (48%) said violence, harassment and abuse resulted from staff shortages (Medical Protection Society, 2023).

> *"I think you definitely get higher sickness levels. You definitely get [see] the morale just go [dip] a little bit when you've got a couple of people – one or two people that are showing that kind of aggression. So that's a bit difficult … and it's hard to manage a team where you're constantly trying to beg someone to go [into work]." – Staff member working in an NHS adult acute mental health inpatient hospital (Rivett & Wood, 2023)*

3.2.2 Staff retention

Evidence suggests that experiencing violence, harassment and abuse negatively impacts on staff retention and increases the likelihood of staff considering leaving the NHS (The Source, 2022; Deery, et al., 2011; Cooper & Inett, 2018). A large survey of staff (n=1,391) from more than 30 NHS London organisations found that 65% of those who had experienced verbal abuse and 71% of those who had experienced physical violence considered leaving the NHS (The Source, 2022). A 2018 survey of ambulance staff found that almost four in ten (37%) considered leaving their job due to the threat of violence (GMB Union, 2018). Bullying and harassment by colleagues can also lead to attrition from student training and placements (British Medical Association, 2017; Gafson, et al., 2017; Üzar-Özçetin, et al., 2021; Carter, et al., 2013; Tee, et al., 2016). For example, one study of student nurses found that one in five (20%) had considered leaving nursing because of incidents of bullying and harassment (Tee, et al., 2016). Furthermore, one study of general practitioners reported examples of older male doctors taking early retirement as a direct consequence of being assaulted (Elston & Gabe, 2016).

> *"I have sometimes been put in situations in which I feel are not suitable for a student. I have considered leaving many times, and my attendance has suffered." – Nursing student (Üzar-Özçetin, et al., 2021)*
>
> *"One of them [staff] was absolutely traumatised by it, you know, to the point I wondered if she would leave." – Staff member working in an NHS low-secure forensic service (Cooper & Inett, 2018)*

3.2.3 Patient quality of care

Evidence suggests that violence, harassment and abuse can also hinder staff from delivering high-quality care to patients. This can occur because the daily demands of working in a high-stress, high risk, negative environment can result in demotivation, decreased engagement and presenteeism among staff (Rivett & Wood, 2023; Carter, et al., 2013; British Medical Association, 2017). A small study of community pharmacists (n=18) found that shortly after experiencing an aggressive incidence they reported a reduction in concentration (17%), an inability to focus (11%), dispensing errors (22%), and 'near misses' (39%) (Irwin, et al., 2013). Further, a study of nursing students found that a fifth of those who experienced bullying and harassment were afraid to check instructions when they were unsure, with 12% reporting that the standard of patient care was negatively affected (Tee, et al., 2016). A study done in two NHS primary care trusts found that more than 30% of staff who experienced bullying and harassment opted to disengage from specific tasks, felt that it diminished their dedication to their job, and curtailed their work hours to steer clear of interactions with the perperator (Burnes & Pope, 2007).

> *"…they might not react but their attitude to work might be different. So ... for example, if they were doing ten tasks … they might decide to do six or seven… I'm not saying that's what I'm doing, but that might happen." – Staff member working in an NHS adult acute mental health inpatient hospital (Rivett & Wood, 2023)*

3.2.4 Financial costs

Whilst there are potential financial impacts due to lower staff productivity, absenteeism, and poor retention due to workplace violence, there are also significant financial repercussions from violence, harassment and abuse towards staff (British Medical Association, 2017). A 2019 study that examined the financial repercussions of bullying and harassment among NHS employees in England, estimated an annual cost of £2.3 billion to taxpayers (Kline & Lewis, 2019). This cost encompassed various factors, including staff health, employer expenses related to sickness absence, employee turnover, reduced productivity, sickness presenteeism, compensation, litigation, and industrial relations costs. Another study, which examined the cost implications of implementing violence reduction interventions in adult mental health wards in East London, identified violence, harassment and abuse as contributing to around 40% of the costs associated with staff sickness absence (Taylor-Watt, et al., 2017). In the financial year before the interventions were introduced, 278 incidents of violence, harassment and abuse were experienced at cost of £945,059 compirsing costs for staff sickness absence, estates costs (for repairs to property damage and replacement of broken items), legal costs, costs associated with staff bank cover and medication costs.

4 Risk factors for violence against staff

The evidence suggests that a range of factors contribute to the occurrence of violence, harassment and abuse within the NHS. Although violence, harassment and abuse are often framed as being rooted in individual behaviours, it is important to recognise that systemic contributions are equally, if not more, important. Many factors outside of the control of staff contribute to the risk of violence, harassment and abuse that they experience.

4.1 Individual (victim) level risk factors

4.1.1 Professional position

Evidence suggests that staff in particular positions and job roles may be at an increased risk of experiencing violence, harassment and abuse. Studies have identified that nurses, healthcare support workers, and students are more likely to receive abuse from patients compared to more senior staff members (Lepping, et al., 2013; Stubbs & Soundy, 2013; Ipsos MORI, 2010; Edward, et al., 2014; Sherwood Forest Hospitals, 2021; Sammut, et al., 2023). Staff in patient-facing roles and settings such as A&E, security, nursing, patient complaints and reception are more likely to experience verbal abuse or threats within the workplace (Ipsos MORI, 2010; Elston & Gabe, 2016; Quine, 2001). The higher incidence of violence, harassment and abuse experienced may be attributed to several factors including length of time spent with the patient, perceived senior authority between members of staff and how this relates to their care and treatment options, communication styles, and misinformation (Edward, et al., 2014).

In relation to bullying and harassment, evidence suggests that staff perceived as having more seniority are more likely to perpetrate bullying (Capper, et al., 2020; Illing, et al., 2013) and studies consistently show that staff members are bullied by their managers (Carter, et al., 2013; Hollins Martin & Martin, 2010; Capper, et al., 2020; Illing, et al., 2013). This is important as managers are strongly implicated in shaping the work environment, they define acceptable behaviours, often implicitly, by role-modelling, rewarding, ignoring, and punishing certain behaviours (Carter, et al., 2013). Therefore, this behaviour was seen to 'filter down' to, for example, how students are treated (Capper, et al., 2020).

"'I was sitting flicking through a massive set of notes and then the consultant walks round the corner and goes; 'What are you doing?' and shouts at me in front of all the nurses, everyone on the ward. Then when you get a bit tearful tells you to grow up in front of everyone, very publicly. Numerous occasions like that, particularly in surgical jobs. Just being made to feel that you're never good enough and never getting any thanks for what you do." – Foundation Year 2 doctor (Smith, et al., 2018)

"Midwives are treated badly by their managers - this filters down to their treatment of students (and women) - the lowest link in the chain." – Midwifery student (Capper, et al., 2021)

4.1.2 Level of experience

Evidence suggests that length of experience in the workplace correlates negatively with violence, harassment and abuse (Lepping, et al., 2013; Üzar-Özçetin, et al., 2021; Hunter, et al., 2022; Edward, et al., 2014; Sherwood Forest Hospitals, 2021; Dickens, et al., 2013). One study found that the overall length of service in the NHS was significantly associated with the likelihood of experiencing verbal abuse (a longer length of service was associated with experiencing less abuse), but not other forms of violence (Lepping, et al., 2013). One possible explanation for this is that more experienced staff may be better able to de-escalate situations to avoid verbal abuse than less experienced staff, whereas it may be more difficult to avoid serious incidents of physical assault once a situation has escalated to that level (Lepping, et al., 2013). Alternatively, staff with more experience may be perceived as more qualified and thus less likely to be verbally abused by patients or visitors (Edward, et al., 2014).

> *"I was disrespected on the basis that I am 'below' qualified staff and because I am a student." – Nursing student (Üzar-Özçetin, et al., 2021)*

Similarly, evidence shows that bullying and harassment is more prevalent amongst less experienced and new members of staff and students, with much of this being perpetrated by more experienced, senior staff (Wilson, 2016; Üzar-Özçetin, et al., 2021; Hallett, et al., 2021; Stubbs & Soundy, 2013; Smith, et al., 2018; Rees, et al., 2015a). Holding a junior status and having a lack of experience within the workplace increases the risk of staff experiencing abuse from their senior and more experienced peers (Üzar-Özçetin, et al., 2021; Rees, et al., 2015a). Common behaviours identified in studies included being humiliated, having information withheld, and being given unreasonable targets and deadlines (Wilson, 2016; Üzar-Özçetin, et al., 2021; Smith, et al., 2018).

Prevalence rates of bullying by other staff, verbal abuse, and physical violence also appear to be higher in studies of students and trainees, compared to overall prevalence rates of all staff, further supporting the idea that having less experience places staff at a greater risk of violence (see Section 2.4). However, studies differ in definitions and measures of violence making direct comparisons difficult, meaning there is a need for more research to be conducted.

4.1.3 Level of patient contact

Evidence suggests there is an association between direct contact time with patients and experiencing abuse, in that the more direct contact staff have with patients and the general public, the more likely they are to experience abuse (Lepping, et al., 2013; Elston & Gabe, 2016; Edward, et al., 2014; Dickens, et al., 2013). One study in three district general hospitals in Wales found that nurses and healthcare support workers were subjected to violence, harassment and abuse more than doctors and other hospital workers (Lepping, et al., 2013). Similarly, a study of general practitioners identified that they were at risk of abuse due to being in constant contact with many members of the public, including those who are socially disadvantaged, sometimes in unfamiliar settings, e.g. homeless hostels and at night (Elston & Gabe, 2016). In settings where staff have prolonged contact with patients (e.g. in mental health

settings), staff may find it difficult to report incidents of violence, harassment and abuse for fear that they will jeopardise the relationship with the patient (Snook & NHS England, 2023).

> *"There is often a very strong working relationship between staff and patient, and they are concerned about damaging the relationship they have with the patient by making a report." – Staff member working in a secondary care mental health team (Snook & NHS England, 2023)*

Level of patient contact may also be influenced by the number of hours worked, for example whether staff are full- or part-time. Whilst evidence suggests that increased patient contact increases the risk of violence, harassment and abuse, one study found that although the overall incidence of abuse was higher among full-time staff, the relative prevalence of aggression towards part-time staff members was higher (Lepping, et al., 2013). However, findings may be confounded by the demographic differences in staff who work full-time comparedto part-time, with groups who may be more at risk of experiencing violence, harassment and abuse, such as females and ethnic minorities more likely to be working part-time (Royal College of Nursing, 2022).

4.1.4 Demographics

Evidence suggests that a range of demographic factors are associated with an increased risk of experiencing violence, harassment and abuse. An employment survey of over 9,000 nurses found that around one in eight (13%) of those who had experienced verbal or physical abuse believed it was discriminatory in nature, and linked to protected characteristics such as their gender, ethnicity, age, sexuality, or whether they have a disability (Royal College of Nursing, 2022).

Evidence suggests that younger age is a key risk factor for experiencing verbal and physical violence from a patient or visitor, and bullying. One study of staff working in London NHS organisations found that 45% of those aged 18-34 years had experienced physical violence, compared to 37% of those aged 35 years and older (The Source, 2022). The study also found that younger staff experienced a wider range of abusive and violent behaviours, on average experiencing 5.4 different types of abuse, compared to the overall average of 4.7 (The Source, 2022). Similarly, an employment survey of over 9,000 nurses found that younger age was perceived as the most common reason for being bullied (Royal College of Nursing, 2022).

In terms of gender, there is mixed evidence on whether males or females are more or less likely to experience violence, harassment and abuse. Several studies suggest that female staff are more likely to experience violence, harassment and abuse (Elston & Gabe, 2016; Hunter, et al., 2022; Rees, et al., 2015a). Additionally, one study, which focused on the extent to which violence against general practitioners is experienced in gendered terms, found that overall, women general practitioners were much more likely to express concern about violence and to take personal precautions (Elston & Gabe, 2016). However, younger male general practitioners working in inner-city practices also had high levels of concern (Elston & Gabe,

2016). A survey of frontline NHS staff found that men were more likely to experience physical abuse (Ipsos MORI, 2010). In terms of bullying and harassment, one study identified that females are often overrepresented among targets of bullying (Illing, et al., 2013), although some studies have found more even proportions (Manolchev & Lewis, 2021).

Evidence suggests that minority groups are at higher risk of experiencing violence, harassment and abuse (Royal College of Nursing, 2022; The Source, 2022; Hallett, et al., 2021; Sussex Health & Care, 2022). An employment survey of over 9,000 nurses found that Black nurses were most likely to have experienced physical abuse, compared to White and Asian respondents and those of mixed ethnic backgrounds (Royal College of Nursing, 2022). Data from one ICS's Workforce Race Equality Standard (WRES) metrics also showed that a consistently higher proportion of ethnic minority staff experienced harassment, bullying and abuse from patients, relatives or other members of the public over a five year period (Sussex Health & Care, 2022). The WRES data showed that in 2022, 35% of ethnic minority staff experienced harassment, bullying or abuse, compared to 28% of White staff (Sussex Health & Care, 2022). There was a higher disparity regarding harassment, bullying and abuse at work from managers and other colleagues, with 24% of ethnic minority staff experiencing bullying compared to 17% of White staff (Sussex Health & Care, 2022). Other minority groups such as LGBTQ+ staff have also been found to be at increased risk of experiencing violence, harassment and abuse. One study of staff working in NHS organisation in London found that over half (52%) of staff who identified as LGBTQ+ had experienced a physical assault from patients or visitors, compared to 37% of staff who identified as heterosexual (The Source, 2022). Furthermore, whilst there were high levels of verbal abuse against all staff regardless if they are from an ethnic minority groups or not, the same study found that verbal abuse against ethnic minority staff was often perceived to be more personal and targeted (The Source, 2022). A significantly higher proportion of ethnic minority staff and staff who identified as LGBTQ+ experienced violence, harassment and abuse related to their race, ethnicity, gender, or sexuality (The Source, 2022).

> *"You hear like some particularly much, much older patients and they can be quite offensive to people's race… a lot of international members of staff at the hospital and the way they speak to some of them is absolutely disgusting… they sort of almost imply they are not doing as good a job but they are doing exactly the same job like it makes no difference." – Nursing student (Hallett, et al., 2021)*

Evidence also suggests that members of the workforce with a long-lasting health condition, illness or disability are more likely to experience violence, harassment and abuse (Royal College of Nursing, 2022; Illing, et al., 2013; Sussex Health & Care, 2022). Data from one ICS's WRES metrics showed that 35% of staff with a long-lasting health condition or illness experienced harassment, bullying or abuse from patients, service users, their relative, or other members of the public, compared to 28% of staff without a condition (Sussex Health & Care, 2022). The prevalence of bullying has also been found to be higher among staff with disabilities or long-lasting health conditions with the WRES metrics showing that prevalence

of harassment, bullying and abuse from colleagues was 25%, 9% higher than people without a long-lasting health condition or illness (16%) (Sussex Health & Care, 2022).

4.1.5 Lack of adequate training

NICE guidelines on the short-term management of violence and aggression recommend that NHS organisations provide staff training in conflict resolution and de-escalation techniques (National Institute for Health and Care Excellence, 2015). A lack of staff training in de-escalation techniques, as well as a lack of training in the causes and treatment of various pathologies associated with violent behaviour, were identified as risk factors across a number of studies (Hallett, et al., 2021; Raveel & Schoenmakers, 2019).

4.1.6 Communication skills

Evidence suggests that good communication, such as talking with or comforting patients, is a protective factor against violence, harassment and abuse. Conversely, poor communication skills can be a risk factor (Knowles, et al., 2013; Dickens, et al., 2013; Raveel & Schoenmakers, 2019; Blackpool Teaching Hospitals, 2022; Pulsford, et al., 2013; Portsmouth Hospitals University, 2022). The use of good verbal and non-verbal communication is also important in conflict resolution. Communication between staff is also important to improve the effectiveness and efficiency of communication across partners, including the exchange of relevant patient information (HSJ & Unison, 2017).

> *"Certain personalities get into arguments…being a jobsworth, 'sorry I can't tell you that…sorry I can't help you with that'. Even if you can't help someone, give the attitude that you would like to help them…the way you come across is quite important." – Staff member working in an NHS Emergency Department in the North of England (Knowles, et al., 2013)*

4.1.7 Workload and stress

Evidence suggests that staff feeling overworked and stressed are key risk factors for experiencing violence, harassment and abuse (Raveel & Schoenmakers, 2019; Health Development Agency, 2001). Overworked staff may be less able to defuse violence (HSJ & Unison, 2017) and the risk of patients perpetrating violent or abusive behaviour may be increased by the frustration of long waiting times for treatment (Medical Protection Society, 2023). Furthermore, the demand of a high workload can affect incident reporting. For example, a recent report from Snook and NHS England about national data collection options for violence, harassment and abuse found that although call handlers in ambulance trusts receive a high volume of verbal abuse, because of a heavy workload, many incidents are not reported (Snook & NHS England, 2023).

Evidence also suggests that there is an association between workload pressures and workplace bullying and harassment (Carter, et al., 2013; Royal College of Nursing, 2022; Johnson, et al., 2019). One study of seven NHS trusts in the North East of England highlighted that staff who are stressed may perpetuate bullying behaviours due to frustration with other

staff not performing in a way that they perceive to be efficient (Carter, et al., 2013). Specifically, managers were recognised as having particularly stressful roles and this high workload may explain the higher risk of managers perpetrating bullying behaviours (Carter, et al., 2013).

> *"Quite often the people doing the bullying are actually stressed…if they are trying to get something done, they're stressed, the people in front of them aren't performing or doing the things they think they should be doing, then they sort of demonstrate that…with certain bullying behaviours…which can verge on being abusive at times." – NHS staff member working in the North East of England (Carter, et al., 2013)*

4.2 Individual (perpetrator)

4.2.1 Substance use

Patient intoxication, and alcohol and substance dependence or abuse are recognised as risk factors that increase the likelihood of violence (Raveel & Schoenmakers, 2019; Knowles, et al., 2013; Sherwood Forest Hospitals, 2021; Health Development Agency, 2001; GMB Union, 2018; Sussex Health & Care, 2022; Royal College of Nursing, 2022; AACE, 2023; Shropshire Community Health, 2021). A survey of ambulance staff found that approximately a half (52%) of ambulance workers had experienced sexual harassment or been assaulted by an intoxicated patient (GMB Union, 2018). Both alcohol and other drugs are perceived as increasing the risk of aggressive behaviour, however, one study of staff working in A&E departments identified that staff spoke predominantly of excess alcohol as the main factor (Knowles, et al., 2013).

> *"While transporting a male patient who was under the influence of both alcohol and drugs he attempted to leave the ambulance while in motion. I tried to explain the danger involved [and] he grabbed me and tried to break my thumbs." – NHS ambulance staff member (GMB Union, 2018)*

4.2.2 Psychiatric conditions/mental illness

Although the majority of patients who receive mental health care are not violent or abusive, a diagnosis of mental illness or a psychiatric condition has been demonstrated to be a factor which increases the likelihood of a patient perpetrating violence, harassment and abuse (Raveel & Schoenmakers, 2019; Knowles, et al., 2013; Portsmouth Hospitals University, 2022; Sussex Health & Care, 2022; Sherwood Forest Hospitals, 2021; The Source, 2022; The Leeds Teaching Hospitals, 2021). This may stem from either having little to no insight into their actions or the consequences of these actions (Royal College of Nursing, 2022; Harrison, et al., 2020). An employment survey of over 9,000 nurses found that just under half felt that physical and verbal abuse was linked to health or personal problems, often where patients may lack capacity due to dementia or mental health problems (Royal College of Nursing, 2022).

"You know, if somebody for instance has some kind of social difficulty or social anxiety or social disorder, then you know that will then manifest through how they interact, how they're able to interact and that could very well be taken as rude." – Staff member working in a mental health role (Harrison, et al., 2020)

4.2.3 History of violence

Evidence suggest that patients with a history of violence are more likely to perpetrate violence (Raveel & Schoenmakers, 2019; Portsmouth Hospitals University, 2022; Wilson, 2016; Sussex Health & Care, 2022; Sherwood Forest Hospitals, 2021). An employment survey of over 9,000 nurses found that 36% of physical violence and 25% of verbal abuse were attributed to the perpetrator having a history of violence or abuse (Royal College of Nursing, 2022).

4.3 Organisational factors

4.3.1 Insufficient policies or prevention work and ineffective management

Evidence suggests that inadequate policies, guidance, and prevention efforts are associated with an elevated risk of violence, harassment and abuse. This highlights the responsibilities of organisations to put protocols, policies, and risk assessments in place (Hallett, et al., 2021; Atawneh, et al., 2003; Illing, et al., 2013; Sammut, et al., 2023). Bullying and harassment is more common in organisations that don't have anti-bullying policies in place (Illing, et al., 2013). Similarly, staff working in general practices which lack established protocols or low enforcement of policies (e.g. prohibiting intoxication) are at a higher risk of experiencing violence, harassment and abuse (Raveel & Schoenmakers, 2019).

Evidence suggests that having insufficient reporting protocols and procedures in place may increase the risk of bullying and harassment behaviours and cultures (Capper, et al., 2020; Illing, et al., 2013). One study of midwifery students showed that they perceived that specific groups within the organisation, particularly managers, did not feel comfortable challenging or punishing staff who perpetrated bulling and harassment (Capper, et al., 2021). Lack of opportunity to register reports and lack of a transparent process around dealing with reports of bullying and harassment were identified as common problems (Capper, et al., 2021; Illing, et al., 2013). Further, a study of almost 3,000 staff working in seven trusts in the North East of England found that staff often perceived that reporting bullying and harassment would result in them being labelled as a troublemaker (Carter, et al., 2013).

"Everyone knows who the bullies are and ignores it. It's far too much trouble to go up against seniors who are bullies. Some degree of bullying seems to be tolerated [in] our NHS society." – NHS staff member working in the North East of England (Carter, et al., 2013)

4.3.2 Staff shortages

Evidence suggests that staff shortages can increase the risk of violence, harassment and abuse (Illing, et al., 2013; HSJ & Unison, 2017). A special report from the HSJ and Unison (2017) found that there was a strong correlation between trusts facing greater financial deficits and an increase in violent assaults, and financial pressures associated with staff shortages. Staff shortages can put pressure on staff by increasing their stress and workload, both of which are factors that increase an individuals' level of risk. Furthermore, staff shortages are likely to result in increased waiting times for patients, another key risk factor for violence, harassment and abuse.

> *"As one of the band 7 ward managers on the acute floor I can confirm that we have had an increase in mental health patients being admitted to the wards in recent months. With the increased admissions of these complex patients we have seen an increase in staff and patient assaults. It is felt that the increase in admissions is in response to the COVID-19 pandemic and the subsequent after effects that it is having on mental health." (The Leeds Teaching Hospitals, 2021)*

4.4 Environmental/situational risk factors

4.4.1 Waiting lists

Evidence suggests that a major risk factor for patient and general public-perpetrated violence, harassment and abuse is long waiting times and the boredom or lack of information associated with these wait times (Raveel & Schoenmakers, 2019; Knowles, et al., 2013; Portsmouth Hospitals University, 2022; AACE, 2023). In a national survey of UK doctors, of those who reported experiencing or witnessing verbal or physical abuse from patients or their relatives in the past 12 months, 48% reported that the incidents were a result of staff shortages and 45% reported that it was due to the referral waiting list (Medical Protection Society, 2023). In one small study of emergency department staff (n=16) working in seven trusts in the North East of England, staff felt that impatience with waiting to be seen or receive treatment arose because some patients expected immediate treatment and perceived their own needs to outweigh those of other patients. This was perceived as particularly being the case amongst younger people with some staff suggesting this was a product of 'changing society', and a "'can't wait' culture" (Knowles, et al., 2013).

> *"Nobody wants to wait…nobody thinks they should wait. Everyone wants fast food medicine: they come in, get immediate treatment, everything's curable and everything can be done straight away and it doesn't matter if two people or 22 people arrive at once because expectations of those who become aggressive is that they shouldn't have to wait." – Staff working in an NHS Emergency Department in the North of England (Knowles, et al., 2013)*

4.4.2 Lone working

Lone working is defined as "working in situations where there is no immediate support from other staff available" (Shropshire Community Health, 2021) and is consistently recognised as

a factor that increases the risk of staff experiencing violence, harassment and abuse (GMB Union, 2018; Shropshire Community Health, 2021; Blackpool Teaching Hospitals, 2022; Health Development Agency, 2001). Staff groups who are likely to work alone include delivery drivers; community based staff; health visitors; out of hours staff who see patients/service users for individual sessions in wards or clinics; podiatrists; school nurses; staff working in isolated clinics; and staff utilising corridors and walkways or between sites where they might not encounter any other colleagues (Shropshire Community Health, 2021; Blackpool Teaching Hospitals, 2022).

> *"I was a lone worker on nights [with] no radio. [I] was attacked by two males wanting drugs (I don't carry them)." – NHS ambulance staff member (GMB Union, 2018)*

4.4.4 Environmental design

Evidence suggests that environmental design of healthcare settings can influence the risk of staff experiencing violence, harassment and abuse (HSJ & Unison, 2017; Sherwood Forest Hospitals, 2021; Portsmouth Hospitals University, 2022; Sussex Health & Care, 2022; Dickens, et al., 2013). Several environmental design features have been identified as having the potential to increase risk, including a lack of information relating to waiting times; poor access/lack of access to TV or reading materials; limited access to private areas; areas that are noisy, too hot/cold, cramped or isolated; and staff working in rooms separated from other working areas (Ipsos MORI, 2010; Illing, et al., 2013; Health Development Agency, 2001)

5 Preventing and responding to violence against staff

Addressing workplace violence is complex and it has been recognised since the early 2000s that the best way to tackle violence against healthcare staff is through a comprehensive multicomponent approach, rather than implementing specific interventions and approaches in isolation. In 2000, the International Labour Organization (ILO), World Health Organization (WHO), Public Services International (PSI) and International Council of Nurses (ICN) launched a joint programme on workplace violence in the health sector (International Labour Office; International Council of Nurses; World Health Organization; Public Services International, 2002). They recommended that interventions and approaches that aim to prevent and respond to workplace violence should include several components such as training of healthcare providers, security measures, and structured workplace violence prevention and management policies.

5.1 Applying a public health approach to violence against staff

Violence is a societal problem but within the workplace it is also a health and safety concern as part of employers' legal duty to ensure the health, safety and welfare of their employees. Taking a public health approach (World Health Organization, 2023) means that violence against NHS staff is seen as a preventable consequence arising from a range of human and systemic factors, rather than being seen solely through the lens of an isolated health and safety incident or as a security concern. The public health approach provides a framework for systematically examining the causes and consequences of violence and using evidence to inform the prevention through interventions, policy and advocacy. Taking a whole system, multiagency approach to working is important for the successful implementation and delivery of public health approaches, ensuring that organisations have a shared vision and utilise a partnership approach that addresses risk (and protective) factors at the individual, relationship, community and societal level. This includes sharing information, collation of data, and delivering a united response through shared language and messages that address organisational practice and cultures that promote violence and support the implementation of a range of prevention activities that address the needs of the community (i.e. staff) and setting (i.e. healthcare settings, including community-based delivery). Trauma-informed practice, as a long-term objective, is being increasingly adopted by the healthcare system (Office for Health Improvement and Disparities, 2022). Utilising a trauma-informed approach assists with understanding the wider context of violent incidents and key principles include having an awareness of the impact, prevalence, and signs of trauma and understanding how patient/staff power dynamics and responses to violent incidents have the potential to retraumatise patients (Sweeney, et al., 2016).

5.2 Statutory requirements, policy and guidance

5.2.1 Legal and policy frameworks

Providers of NHS services have a statutory obligation under the Health and Safety at Work Act 1974 to prevent, minimise and control the risks of violence, harassment and abuse and under the Management of Health and Safety at Work Regulations 1999 they must assess risk in the workplace, including the risk of violence. In 2018, the Assaults on Emergency Workers Act (Offences) 2018 came into force and the Department of Health and Social Care launched the NHS violence reduction strategy with a focus on a zero tolerance approach to violence. Since 2021, providers of NHS services must have regard to the national Violence Prevention and Reduction (VPR) standard. The VPR standard was designed with the intention of acting as a risk framework to support a safe and secure working environment for NHS staff (Box 1) (NHS England & Social Partnership Forum, 2020). The standard is underpinned by the existing health and safety legislation and supports NHS organisations through a cycle of reviewing their current status against the VPR standard and identifying their future requirements.

Box 1: Violence Prevention and Reduction standard (NHS England & Social Partnership Forum, 2020)

The NHS Violence Prevention and Reduction (VPR) standard was developed in collaboration with the Social Partnership Forum. The standard requires that all commissioners and providers of NHS services have regard to the standard and align their individual incentives with its requirements. The standard currently incorporates the Plan, Do, Check, Act (PDCA) approach, a cycle that enables its users to develop and improve their processes whilst continuously reviewing the effectiveness of the changes made.

Plan: Reviewing existing practices against the VPR standard, assigning roles and accountability, identifying future objectives, and identifying methods of measuring success.

Do: Organising and introducing the new plans and procedures to NHS staff and their stakeholders, providing adequate resources, and training and conducting thorough risk assessments.

Check: Assessing and correcting where any gaps or issues lie, ensuring that processes are seamlessly implemented and conducting appropriate data analysis of violent incidents.

Act: Reviewing the performance of introduced measures. Consulting with management to inform adequate changes, to share findings from data collection to wider stakeholders and to use the lessons learned from the process to inform changes to any policies and plans.

5.2.2 Local and trust level policies

At a local or trust level, we identified examples of policies that provided guidance on how trust leads could adhere to the national VPR standard, ways of assigning accountability to management roles, and legal actions that could be taken. Policies also clarified staff responsibilities and roles, for example when management or security should be consulted. We also found examples of public facing policies supporting the implementation of zero-tolerance approaches to violence, harassmentand abuse, informing patients of what would be

considered appropriate and inappropriate behaviours and what actions may be taken if these rules were abused, including in hospitals, general practice and the ambulance service.

5.2.3 Specific areas of focus for policy and guidance

5.2.3.1 Restrictive practices

Managing violence and aggression with restrictive interventions is highly regulated in healthcare settings (Khwaja & Tyrer, 2023). The National Institute for Health and Care Excellence (NICE) guidelines published in 2015 advise on the short-term management of violence and aggression in mental health, health and community settings in adults, and young people and set out recommendations for 'best-known' practice in relation to anticipating and reducing risks, preventing violence and aggression and using restrictive interventions (National Institute for Health and Care Excellence, 2015). For staff working in mental health settings, the Mental Health Units (Use of Force) Act 2018 (Department of Health and Social Care, 2021) requires that a use of force policy is published for the setting.

5.2.3.2 Lone working

Employers have a legal responsibility to protect lone workers and guidance is available from the NHS Staff Council Health, Safety and Wellbeing Group (NHS Employers, 2022) for improving the safety of lone working. The review identified several trust level policies and recommendations for how risks to lone workers could be reduced, for example from Blackpool Teaching Hospitals Foundation Trust (Blackpool Teaching Hospitals, 2022) and Shropshire Community Health NHS Trust (Shropshire Community Health, 2021).

5.2.3.3 Special allocation scheme

In GP settings, patients who are violent or aggressive may be removed from practice lists to minimise the risk to staff (British Medical Assocation, 2020). Removal of patients must comply with the General Medical Services (GMS) Regulations. For patients removed from practice lists for being violent or aggressive, the Special Allocation Scheme ensures that they can continue to access primary care services at a designated GP practice (British Medical Assocation, 2020).

5.2.3.4 Bullying and harassment between NHS staff

There was recognition in the NHS Long Term Plan (Department of Health and Social Care, 2021) about the need to tackle harassment, bullying or abuse from other staff and the NHS People Plan 2020/21 set out the vision to promote a culture of civility and respect across the NHS. The Civility and Respect programme was therefore established to support NHS organisations to create positive workplace cultures. Outputs include a toolkit supported by a bullying cost calculator (NHS England, 2021). The NHS Staff Council Health, Safety and Wellbeing Group also provide guidance and resources on workplace bullying.

5.2.3.5 Domestic violence and abuse experienced by NHS staff

There is growing recognition of the need for good practice regarding support for NHS staff who experience domestic violence and abuse. Guidance about how NHS organisations can develop a workplace policy for domestic violence and abuse was published by the NHS Staff Council's Health, Safety and Wellbeing Group in 2022 (NHS Staff Council Health, Safety and

Wellbeing Group, 2022). However, a team at the University of Bristol, who are leading the PRESSURE study about primary and community healthcare professionals' own experiences of domestic abuse, have reported initial findings that suggest that very few general practices (Gregory, et al., 2023).

5.3 Interventions and responses

Approaches to workplace violence may broadly be differentiated into whether they are preventive, protective or post-incident measures. Preventive measures aim to reduce the risk of violence, protective measures are related to behaviours and procedures involved in handling a violent incident as it occurs, and post-incident measures aim to reduce the negative impact of violence. A whole systems approach to violence prevention and reduction aims to ensure that across each of these measures, a coordinated and collaborative approach is implemented. This section provides an overview of evidence-based interventions and approaches with example case studies.

5.3.1 Whole systems approach to violence prevention

The global evidence base suggests that strong leadership is necessary to both cultivate and enforce cultures that provide an environment for successful workplace violence prevention programmes (Fricke, et al., 2023). From the case studies it was clear that multidisciplinary collaboration is important to support the effective implementation and delivery of violence prevention interventions. Most interventions described within the case studies collated for this report mentioned efforts to incorporate partnership working practices and two case studies, described below, demonstrate examples of whole systems leadership on violence prevention based around the VPR standard and a public health approach to violence prevention.

The introduction of Integrated Care Systems (ICSs) across England has brought together NHS organisations, local authorities and others and they therefore provide opportunities to work collectively and at scale on violence prevention and reduction activities. **Intervention case study 1** describes how NHS Sussex ICS have utilised a whole systems approach, based on a trauma-informed and public health approach to violence to increase the number of NHS workers reporting incidents of violence, aggression and harassment across the ICS footprint. The ICS has aligned their approach with the six key principles of trauma-informed practice (safety, trust, choice, collaboration, empowerment, and cultural consideration) and are prioritising multidisciplinary work. **Intervention case study 2** describes another approach to systems leadership through the application of a Community of Practice approach to prevent and reduce violence within the NHS Suffolk and North East Essex ICS footprint.

Intervention case study 1 – Systems leadership through NHS Sussex ICS

Context and aims of the work:

NHS Sussex ICS is one of six pilot sites delivering the NHS VPR standard under ICS leadership. This approach shifts away from the traditional lens applied towards the implementation of a trauma-informed, public health approach, with responsibility sitting within the People Directorate. The work is led by VPR Leads with each NHS organisation. Key stakeholders include the five NHS hospital trusts, three local authorities, two ambulance trusts and the Sussex Violence Reduction Partnership. Six objectives have been outlined which contribute towards achieving the overall goal of staff feeling safe, supported, and secure at work:

1) Building a trauma-informed leadership culture that ensures that all staff are valued in their organisation and have the opportunity to voice their concerns.
2) System-wide policies and procedures that ensure thorough training opportunities, clear reporting systems, assigned accountability, and sufficient support for staff following incidents.
3) Active encouragement of incident reporting and subsequent follow-up action from management.
4) Clear support plans in place for members of the workforce.
5) Local partnership working to ensure an adequate public health approach for effective violence prevention action.
6) A clear understanding of risk factors and ways to reduce risks with the help of local partners.

Intervention overview:

Key priorities are:

1) A trauma-informed approach to increase reporting.
2) Development of a governance and assurance process to allow for strategic oversight, consideration, and decision-making.
3) Development and annual review of action plans at Trust level.
4) Reaching full compliance with the VPR standard by March 2024.
5) Implementation of trauma-informed pilot projects and exploring violence prevention and reduction through a trauma informed lens.

The ICS have also seen the disproportionate representation of BAME groups in their workplace violence data and a pilot has aimed to enhance data collection by including protected characteristics of both victims and perpetrators of violence. The purpose is to gain a greater insight into patient violence and understand underlying motives for violence towards staff, whilst also not placing blame on, or criminalising, patients. Having this understanding could help in identifying barriers that specific populations face, allowing for tailored support to be developed.

Intervention evaluation and impacts:

Monthly incidence data from the trusts is fed into the ICS People Committee and a progress report was published in 2023. Sussex ICS are on track to meet their objectives. All trusts have developed individual action plans and trauma informed practice is being implemented across the region. The full impact is expected to be seen in the long-term and may take some time to fully embed into the system. The ICS are part of the pilot for the Royal Society Public Health Level 3 and 4 course (see Box 2) and have contributed to a training needs analysis for the development of the course. An evaluation of this will be available in future.

Implementation challenges:

The work is regarded widely as being successful, but notable challenges have been identified. A significant challenge to implementing a trauma-informed, public health approach is the embedded culture around violence prevention and reduction. Many early approaches follow a zero-tolerance approach, which clashes with the goals of trauma-informed practice and there has been a reluctance from some organisations accustomed to the traditional approach.

Intervention case study 2 – Community of Practice in NHS Suffolk & North East Essex ICS

Context and aims of the work:

NHS Suffolk and North East Essex ICS covers two integrated community and acute trusts and one ambulance trust. The overarching approach of the ICS is to foster a culture of non-acceptance of violence against staff, in order to help enhance staff wellbeing and reduce sick leave. The ICS is transitioning from a reactive to a preventive approach via the implementation of training programmes on de-escalation, trauma-informed care and understanding patient needs.

Intervention overview:

A Community of Practice (CoP) was established to align incentives and benefits across all participating trusts and bi-monthly CoP meetings and monthly catch ups with trust leads have been set up to foster collaboration and knowledge sharing. The scope of the work within the CoP has encompassed several key areas:

1. Reporting campaigns to encourage staff to report incidents. The campaigns are intended to emphasise to staff that dealing with violence is not part of their job description and highlight the focus on staff wellbeing.
2. A focus on multidisciplinary working practice by introducing the concept of violence prevention, encouraging discussions on best practices, innovative ideas, and areas for improvement.
3. Recognising the role of trauma in triggering patient violence and aggression. Strategies have been developed, including a basic resource pack for each trust, that address reporting procedures, local and national support services, ideal patient environments, de-escalation techniques, and training options.

Intervention evaluation and impacts:

Collaborative working and knowledge sharing has been seen to allow for practical implementation of work around violence prevention and reduction in various areas of expertise. The overarching work is being evaluated as follows:

1) Tracking rates of staff reporting violent incidents to see if they increase after reporting campaigns, which could indicate an improved reporting culture rather than more actual incidents. The reporting campaign has been seen to be successful due to an increase in reporting.
2) Tracking the number of staff accessing support services and taking sick days due to violent incidents, to see if these numbers decrease over time.
3) Developing longer-term key performance indicators around staff retention and wellbeing.

Implementation challenges:

The ICS have faced some challenges, notably that the concept of violence prevention is new for many organisations. Getting buy-in and momentum from certain stakeholders has proved challenging. The work has demanded a shift in culture across all trusts, a process that has been inherently time-consuming and which has discouraged some stakeholders from being involved.

5.3.2 Risk assessment

Risk assessment is a key feature of UK health and safety legislation and has a fundamental role in risk management. Risk assessment may be pro-active or reactive and when used proactively can be used to identify and anticipate the risks which may lead to incidents of violence, harassment and abuse. However, risk assessment methods often follow a linear chain of events approach and may therefore miss the range of human and systemic factors that contribute to the occurrence of workplace incidents including violence (Dallat, et al., 2019).

To meet the VPR standard (Box 1), NHS organisations are required to carry out regular workforce and workplace risk assessments. However, currently there is a lack of evidence to guide risk assessment practices within the NHS. Kaya et al. (2021) suggest that formal risk assessment practice within the NHS could be improved by learning from the safety management literature.

Several trust level policies we identified through the grey literature searches referred to individual assessments for patients who on admission are identified as having a history of, or display signs of, violence and aggression. Structured risk assessments are widely used in mental health settings to identify patients who are at risk of becoming violent and research has shown the value of two tools, the 'Brøset Violence Checklist' and the 'Dynamic Appraisal of Situational Aggression' (Dickens et al., 2020). Risk assessment tools are also increasingly being used in emergency departments, but recent reviews (Sammut, et al., 2023; Cabilan & Johnston, 2019) have found that high-quality evidence is lacking for valid and reliable risk assessment tools. In the absence of evidence for any particular tool, Sammut et al. (2023) recommend choosing a tool that aligns most strongly with the specific context in which it will be used. The STAMP framework (Luck, et al., 2007) is a widely cited emergency department risk assessment tool.

5.3.3 Staff education and training

Staff education and training are an important component of violence prevention and response approaches and may cover a broad range of techniques including education to enhance knowledge and understanding of policies and procedures and violence control strategies including conflict resolution and de-escalation techniques and restraint reduction training. Specific programmes may target staff interpersonal skills and a trauma-informed approach to training aims to build an understanding of the underlying causes of patient violence and aggression through a focus on emotional intelligence, compassion and reflective practice. All nine case studies discussed some element of staff training and training was recognised as essential for the workforce. However, while staff may gain knowledge and confidence from training, a recent Cochrane review (Geoffrion, et al., 2020) reported low certainty in the evidence linking education and training programmes to reductions in violence, harassment and abuse against healthcare staff.

5.3.3.1 Public health approach to violence prevention

Educational programmes and pathways have recently been developed for NHS staff on the public health approach to violence prevention and reduction (Box 2). The Royal Society for Public Health (RSPH), in collaboration with NHS England and with support from organisations within NHS Sussex ICS, carried out a training needs analysis to identify views among NHS leads on improving NHS workplace culture and training needs related to violence prevention and reduction work, gaps in the skills required to deliver best practice and learning needs for effective training. The findings suggested a focus on a trauma-informed, public health approach to violence prevention and reduction, as well as collaboration with external stakeholders (Royal Society For Public Health & NHS England, 2023). The training needs analysis also identified a need for training in emotional intelligence and reflective practice skills to underpin the work towards an organisational culture shift in the approach to violence

prevention (Royal Society For Public Health & NHS England, 2023).The Social Partnership Forum has called for a system wide action across the NHS to create positive workplace cultures and to tackle bullying and harassment (Social Partnership Forum, 2019). Although links may not directly be made within the evidence to the impact on violence, harassment and abuse against staff, these broader issues of culture within NHS systems are relevant and many studies emphasise the need for training and organisational investment to support positive workplace cultures to tackle violence, harassment and abuse (Capper, et al., 2021; Harrison, et al., 2020; Thompson, et al., 2020).

Box 2: NHS England Violence Prevention and Reduction Education Pathway

The Violence Prevention and Reduction Education Pathway comprises two accredited delivery programmes developed by external partners in collaboration with NHS England. The Royal Society of Public Health has developed qualifications at levels 3 and 4 and Liverpool John Moores University at levels 6 and 7. The programme is designed to meet the training needs of both Operational Leads and Strategic Specialists employed by NHS organisations.

The training provided by the Royal Society of Public Health includes Level 3 and Level 4 qualifications for Strategic Specialists with day-to-day responsibility for leading violence prevention and reduction within their organisation across various healthcare settings including primary care, emergency care, voluntary and specialist secondary care workers. In addition, a Level 3 qualification is provided for Operational Leads who lead care delivery in those environments identified as being 'at-risk'. The pathway focuses on implementing appropriate strategies in response to violent incidents from patients. Both individual factors, such as patient trauma and anxiety, and structural factors are considered.

The training delivered by Liverpool John Moores University consists of continuing professional development modules at Level 6 and Level 7, both of which are aimed at Violence Prevention and Reduction Leads within healthcare organisations. The training aims to strengthen the public health capacity and capability of senior staff through enhancing understanding of the application of a public health approach to violence prevention. Partnership is encouraged with other peers who have responsibility for violence reduction. Students are expected to act as advocates for violence reduction within and outside their own organisations and build on the notion that effective violence reduction requires a multidisciplinary cadre of frontline staff who work at different levels and have different jobs, but who need to know about, understand and respect what others are doing.

5.3.3.2 Managing violence and aggression

Conflict resolution techniques and de-escalation strategies aim to prevent the escalation of irritation, agitation and aggression into violent incidents and are often used as alternatives strategies to restraint and seclusion. Conflict resolution training is mandatory for all frontline NHS staff and is seen as an important component in the prevention and reduction of violent incidents in the workplace both by employers and their representatives (Blackpool Teaching Hospitals, 2022; AACE, 2023; UNISON, 2021). The NHS conflict resolution training programme addresses communication, patterns of behaviour, recognition of warning signs, impact factors and preventative strategies. **Intervention case study 3** describes how Northampton General Hospital NHS trust have adapted the national syllabus for conflict resolution training at a trust level.

Intervention case study 3 – Conflict resolution training at Northampton General Hospital NHS Trust

Context and aims of the work:

Northampton General Hospital NHS Trust have implemented a nationally mandated conflict resolution training course, which equips staff with communication and empathy skills to aid in dealing with agitated patients. The trust has also established a Violence and Aggression Reduction Group to facilitate discussion on current issues and strategies for improvement, notably collaborating closely with safeguarding teams to make a significant impact.

Intervention overview:

The Trust uses the strengths-based "three conversations model" that originated from adult social care. This adaptation to the conflict resolution training model emphasises empathy, communication skills, and understanding of the patient experience. Overall, the training aims to encourage an understanding that patient violence often stems from fear and discomfort within the hospital setting. Potential conflicts can therefore be resolved by recognising barriers to effective communication and understanding signs of neurodiversity and cultural differences. The training is tailored to individual needs including in medical background, knowledge and experiences. Training is repeated every three years.

Intervention impacts and evaluation:

The Trust believes that the model has contributed to a more holistic and effective approach to violence prevention. Staff feel enabled to use empathetic skills with patients, to see issues from their perspective, and reflect on their own behaviours. Additionally, the initiative has led to improved management of specific issues, such as among patients attending for alcohol detoxification, through the identification of problems and the establishment of more effective support systems.

Implementation challenges:

- The predominance of e-learning programmes is considered an obstacle in relation to the effective delivery of interpersonal skills.
- The Covid-19 pandemic is thought to have exacerbated incidents of violence, harassment and abuse, with factors outside of the Trust's control (such as mask mandates) often leading to triggers and confusion in patients.

NICE guidelines on the short-term management of violence and aggression also recommend that NHS organisations provide staff training in de-escalation (National Institute for Health and Care Excellence, 2015) (Box 3). However, a robust evidence base is currently lacking to inform best practice for de-escalation training (Hallett & Dickens, 2017; Spencer, et al., 2018). For example, a recent rapid review commissioned by NHS Improvement (RAND Europe, 2019), did not find sufficient high-quality evidence that de-escalation training reduces violent incidents, but there was some evidence that it can help staff to manage patient aggression.

Box 3. Recommendations for staff training on de-escalation

Health and social care provider organisations should give staff training in de-escalation that enables them to:

- Recognise the early signs of agitation, irritation, anger and aggression;
- Understand the likely causes of aggression or violence, both generally and for each service user;
- Use techniques for distraction and calming, and ways to encourage relaxation;
- Recognise the importance of personal space; and,
- Respond to a service user's anger in an appropriate, measured and reasonable way and avoid provocation.

From: Violence and aggression: short-term management in mental health, health and community settings (National Institute for Health and Care Excellence, 2015)

5.3.4 Awareness raising and campaigns

Interventions may involve raising awareness of issues surrounding violence, aggression, and harassment as a form of support for those involved, accountability for specific actions, and as a means to campaign for a shift in culture. Recent campaigns have focused on raising awareness among members of the public about the impact of violence and aggression towards emergency care staff (including paramedics and emergency dispatchers) and towards staff working in general practice. The Association of Ambulance Chief Executives (AACE) responded to a significant rise in attacks on ambulance staff following the pandemic via a social media campaign #WorkWithoutFear described in Intervention case study 4. The campaign focuses on spreading awareness to the public about the everyday abuse and harassment faced by emergency staff (Hicking, 2022). Other campaigns which target public awareness have included the 'No Excuse for Abuse' campaign launched in hospital trusts (e.g. University Hospitals Coventry and Warwickshire NHS Trust and Bolton NHS Foundation Trust), and the Institute for General Practice Management campaign video, 'If I die it will be your fault', designed to raise awareness of abuse directed towards staff working in general practice. West Yorkshire Health and Care Partnership have recently launched a campaign 'Leaving a Gap' about the consequences of violence, harassment and abuse towards staff working in primary care, including in general practice and community pharmacy (West Yorkshire Health and Care Partnership, n.d). UNISON, the largest health union in the UK, campaigns on the issue of violence and provides members with information on their rights and actions that can be taken when violent incidents occur (UNISON, 2021).

Intervention case study 4 - #WorkWithoutFear campaign from the Association of Ambulance Chief Executives (AACE)

Context and aims of the work:

In February 2022, AACE launched a national violence and aggression campaign #WorkWithoutFear in response to a rise in violent, aggressive, and abusive behaviour from patients and the public, particularly over the course of the pandemic. The campaign aims to both spread awareness of the day-to-day abuse towards emergency workers and humanise emergency workers to the public.

Intervention overview:

The #WorkWithoutFear campaign messaging is delivered through various posters showcasing quotes from emergency workers from across England about their experiences of violence and aggression. The aim is to raise awareness of the impact of violence and aggression on staff as individuals. The posters include images of workers both in and out of their uniforms.

Intervention evaluation and impacts:

The impact of the #WorkWithoutFear campaign is being tracked through social media engagement. The campaign has been perceived to be successful based on social media engagement, uptake across other NHS organisations and media attention and promotion.

5.3.5 Risk control and protective measures

5.3.5.1 De-escalation techniques and minimising restrictive interventions

Within the last decade there has been a focus on promoting practices which minimise the use of restrictive interventions across the NHS. Restrictive interventions can include physical restraint, mechanical restraint, chemical restraint (rapid tranquillisation), seclusion, segregation and enhanced observation (Department of Health, 2014). Restrictive practices can be associated with harmful effects for service users and can affect staff emotional wellbeing (Lawrence, et al., 2022). NICE guidelines on the short-term management of violence and aggression recommend that staff who work in settings where restrictive approaches may be used are trained in de-escalation techniques to avoid or minimise the use of such interventions (National Institute for Health and Care Excellence, 2015). Hallett and Dickens (2017) have identified five important attributes of de-escalation (communication, self-regulation, assessment, actions and safety) and these correspond broadly with two models that advocate for flexibility in the use of different skills and interventions as part of de-escalation strategies: the Dix and Page ‘ACT’ model (Dix & Page, 2008) and the ‘Safewards’ model (Bowers, et al., 2015).

For training that involves the use of restraint techniques, the Restraint Reduction Network Training Standards (Ridley & Leith, 2021) provide a national and international benchmark for training. They are also mandatory for all training with a restrictive intervention component that is delivered to NHS commissioned services for people with mental health conditions, learning disabilities, autistic people and people living with dementia in England. The standards promote a person centred, human rights-based approach. The Restraint Reduction Network will also offer qualifications at Level 4 and Level 5 in reducing restrictive practices from 2024.

Through our discussions to develop the case studies, we became aware of a need to better understand the context for the use of restrictive interventions in urgent and emergency care

settings. For example, the Association of Ambulance Chief Executives (AACE) is working towards introducing a national training programme in restrictive intervention skills for ambulance trusts (AACE, 2023). However, to date, there has very little published on the use of restrictive interventions outside of inpatient mental health settings both in the UK and internationally. A recent Australian study of the use of restrictive interventions in emergency departments found that an estimated four patients per 1,000 presentations were managed with a restrictive intervention (Knott, et al., 2020), highlighting the need for a greater focus on this area.

5.3.5.2 Restrictive intervention reduction programmes

NICE guidance also recommends that health and social provider organisations that use restrictive interventions have a restrictive intervention reduction programme. The 'Safewards' model (Bowers, et al., 2015) has been recognised within UK guidelines for reducing restrictive practices (Department of Health, 2014; National Institute for Health and Care Excellence, 2015) and there is evidence supporting its use in mental health settings (Finch et al., 2021). Other models that have been adapted for and examined in a UK context include the 'Six Core Strategies' model (Duxbury, et al., 2019) and 'No Force First' (Merseycare, 2013; Haines-Delmont, et al., 2022), which is described in **Intervention case study 5**.

Intervention case study 5 – 'No Force First' approach in Mersey Care NHS Foundation Trust

Context and aims of the work:

'No Force First' was first piloted in 2013 with the aim of reducing physical restraint and other restrictive practices, and ensuring the safety of patients and healthcare workers. The approach encourages a shift to a recovery-oriented perspective, which prioritises the human rights of service users alongside their care and support needs. 'No Force First' has been implemented in adult mental health, complex care for older individuals, learning disabilities services, and specialist services for addiction treatment.

Intervention overview:

There are six key intervention components:

1) Service user and team member experiences of physical restraint are integrated into a Personal Safety Service induction for new staff.
2) The ward manager and matron conduct bi-monthly audits of handovers to confirm alignment with guidelines. *Restrictive practice action plans* undergo regular review by lead nurses and are discussed in monthly meetings of the Restrictive Practice Monitoring Groups, facilitating peer-sharing of best practice. Data analysis identifies wards with elevated incident rates, prompting the provision of assistance and advice.
3) *Post-incident debriefing* provides immediate support to staff and is used as a tool for learning. A collaborative approach is taken, based on a culture of continuous improvement. Service users are involved in debriefs to understand their perspectives and experiences, to contribute to de-escalation and to decrease the likelihood of future incidents.
4) *Positive handovers* involve describing patients in a factual yet empathetic manner. It promotes balanced discussions and avoids singling out patients as difficult or violent. The approach aims to avoid stigmatising labels and encourages staff to lead with empathy.

Intervention case study 5 continued

5) *Mutual help meetings* provide a platform for service users to voice concerns, share ideas for ward improvement, and foster collaboration between staff and service users.
6) *Individualised "meaningful days"* involve structured activities for patients, such as education or employment programmes, volunteering, and health-focused programmes that align with patient's interests, aspirations and recovery goals.

Intervention evaluation and impacts:

A continuous quality improvement approach is employed, including:

1) Analysis of data related to physical interventions, assaults, and seclusions.
2) Learning from incident debriefs, action plans and reviews, and audits during handovers.
3) Patient and family feedback to identify opportunities for improvement.

Identified impacts include a reduction in restraint and physical interventions, resulting in lower patient trauma and re-traumatisation. Patients and service users have reported higher levels of satisfaction due to feeling respected and cared for, with their needs addressed in a timely and empathetic manner. Meaningful activities are provided, reducing boredom and frustration, and improving patient recovery, and reducing readmissions. Data collected since the start of the campaign has shown reduced injuries among staff during physical interventions and lowered sickness rates. It has also improved staff-patient relationships, fostering compassion and empathy. Additionally, staff are reported to benefit from post-incident debriefings as it enhances their wellbeing and contributes to the reduction of future incidents.

Implementation challenges:

A particular challenge is refining the timing and approach for conducting the debriefings and engaging service users effectively. For example, patients with complex needs could still be triggered and distressed by an incident, meaning a debrief taking place too soon after an incident against a staff member would be unproductive, but leaving the debrief until too late could mean the staff member feels unsupported. Additionally, implementing No Force First comprehensively takes time and dedication and in order for other trusts to consider adopting its principles, a commitment to the necessary resources is required.

In forensic and secure mental health services additional considerations are needed with regards to the provision of appropriate levels of physical, procedural and relational security (NHS, 2010). Relational security is "the knowledge and understanding staff have of a patient and of the relational and physical hospital environment, and the translation of this into appropriate responses and care" (Markham, 2022). It has increasingly been recognised as the element in a three-pronged approach to security (alongside physical and procedural security) that has the most significant impact on patient care. **Intervention case study 6** describes the London SiMHS (Safety in Mental Health Settings) project, which is applying the See Think Act framework for relational security alongside a trauma-informed approach to tackle violence against staff across the ten London mental health trusts.

Intervention case study 6 – London Safety in Mental Health Settings (SiMHS) project

Context and aims of the work:

The SiMHS project was established by the London Cavendish Square Group (a group made up of all London Mental Health trusts) in 2019 due to concerns about growing incidents of violence in mental health settings. The focus of the project in on patient violence towards NHS staff members but also patient-to-patient and staff-to-staff incidents. The key aims of the project are to explore how violence and aggression manifests within adult acute care wards and psychiatric intensive care units.

Intervention overview:

Investigatory stage: During this stage the team aimed to gain more perspective about the scope of violence across the mental health settings prior to planning any action to prevent violent incidents. It involved the analysis of incident data across trusts, in-depth thematic analysis of 29 serious incidents, and exploration of service user's experiences.

Intervention phase 1: The team delivered several interventions including:

a) A pilot study of the See, Think, Act framework, which focuses on enhancing relational security across secure/forensic mental health settings. The team received feedback that the pilot was successful and accessible, therefore they started to deliver more training on the framework to ward-based facilitators who would then act as experts to help educate the rest of the ward staff on how to implement the framework.

b) Creation of a dedicated leadership programme for managers with a strong focus on safety and safety improvement.

c) Implementation of a trauma-informed approach, including training for staff on what a trauma-informed approach is and why it is important, developing a position statement as a resource for trusts on trauma-informed care, and conducting a survey to help gauge how much work trusts have done and what would be helpful going forward.

Intervention phase 2: A second phase is planned, including continuing to work to improve relational security and the experience of patient observation; and exploring how the mental health trusts can better tackle racism and discrimination in mental health settings.

Intervention evaluation and impacts:

The National Collaborating Centre for Mental Health conducted an evaluation focused on some of the initial work and found primarily positive results but also key learning points. Individual trusts also track progress against measures including the extent and nature of violence and aggressive incidents. Case studies were collected across the trusts about experiences of piloting the framework and impacts on clinical practice, including:

1) A reduction in violence and aggression in mental health inpatient wards.
2) Strengthening of relational security between staff and patients through enhanced communication and understanding of patient experiences.
3) Managers have self-reported enhanced leadership skills and positive changes in ward culture.
4) A successful community of practice has been established, with members reporting it being an accessible place for sharing knowledge and learning.

Implementation challenges:

Engaging stakeholders, with varying levels of commitment due to frequent NHS staff turnovers among key figures. It was particularly difficult when the executive team lacked buy-in. Due to the number of interventions across the NHS, there is a "crowded marketplace". Therefore, it can be difficult to ensure stakeholder and trusts' engagement due to some leads being involved in or prioritising other initiatives.

5.3.5.3 Workplace design and security technologies

There is evidence from the international literature that some elements of environmental design affect the incidence of violence against healthcare staff (MohammadiGorji, et al., 2021). Overall, research suggests that where environmental factors such as noise, the number of people in proximity, temperature and availability of seating are good, this has a positive impact on staff safety and security in the workplace (Ipsos MORI, 2010). In 2011, the Design Council partnered with the Department of Health and three NHS trusts to research, co-design and test design solutions to violence and aggression in A&E departments. Specific physical changes made within the environment included the provision of more comfortable seating and displaying live information on waiting times and the number of patients being looked after (Ayling & Makin, 2015). Evaluation of the programme identified that it had improved patient experience, reduced hostility and aggression and represented good value for money (Design Council, n.d).

Examples of security technologies implemented within NHS settings include CCTV, non-contact patient monitoring and management systems, body worn cameras and safety and security alarms. However, the availability and strength of the evidence is currently limited across these measures with generally only pilot evaluations available. Oxevision technology is an example of a non-contact patient monitoring platform that has been used in acute inpatient mental health settings within the NHS. The technology has been evaluated in a small number of NHS settings from a patient safety perspective (Dewa, et al., 2023) but the effects on violence against staff have not been explored in the evaluations to date. Body worn cameras and personal alarms have also been used across NHS settings to respond to violence, harassment and abuse from patients. The NHS Long Term Plan (Department of Health and Social Care, 2021) pledged an investment of £8 billion to pilot the use of body worn cameras and they have since been trialled by ambulance service crews (NHS London Ambulance Service, 2021; RAND Corporation, 2023). They have also been piloted in inpatient mental health services (Ellis, et al., 2019; Hardy, et al., 2017) and introduced to Emergency Departments. Different types of safety and security alarms have been used within healthcare settings including stationary panic buttons, audible personal alarms, and complex mobile personal alarms. The Health and Safety Executive consider that provision of personal communication devices (including telephones, mobile phones, radios, automatic warning devices and emergency alarms) may form part of a number of reasonably practicable control measures to help manage the risk of workplace violence (Health and Safety Executive, n.d.). However, evidence for the effectiveness of personal security alarms is limited and little research has been done to examine the different ways in which different types of alarm systems may be effective across settings (Perkins, et al., 2017).

5.3.6 Post-incident measures

5.3.6.1 Incident reporting

Many trust level policies set out procedures for and encourage staff to report all incidents of violence, harassment and abuse. They also offer guidance on how to report incidences of violence in the workplace. Under health and safety legislation, certain workplace injuries, including death, a specified injury and a physical injury that means an employee is unable to

carry out their normal duties for more than seven days must be reported to the HSE under the RIDDOR. Most NHS organisations have electronic reporting systems to record any incidents, risk factors, and general workplace management resources (e.g., the DATIX Risk Management Information system is used widely across the NHS). Other methods can include paper forms that can be filled out or a formal report recorded by suitable managers. The Health and Safety Executive recommend that employers introduce alternative options for staff to report incidents, such as reporting via mobile apps or online applications**. Intervention case study 7** provides an example of a Data Dashboard developed by NHS Lancashire and South Cumbria ICS.

Intervention case study 7 – A data dashboard for NHS Lancashire and South Cumbria ICS

Context and aims of the work:

As part of a new programme of violence prevention and reduction work at the ICS level, a data dashboard has been created, which converts all violence data into a graphic style that visualises real time data and DATIX entries.

Intervention overview:

The dashboard serves as a predictive tool to demonstrate trends in violent incidents, aiding in identifying potential spikes. The data is anonymised and the homepage provides a regional overview and tabs provide localised data by organisation. To date, the dashboard has been piloted with data collected in one Trust, and there are plans to incorporate all violence data from NHS organisations within the ICS footprint. Future plans include incorporating police data to track community crime trends and repeat violent behaviour. Other long-term goals include exploring the broader impact of violence on communities, considering factors like housing and health. The process of creating the dashboard has revealed the necessity of data for informed action and culture change in reporting among healthcare workers. Additionally, there are discussions about incorporating sexual violence and staff absence costs into the dashboard for a more comprehensive overview.

Intervention evaluation and impacts:

The work is reviewed annually. The goal is to eventually create a report comparing the data dashboard and other interventions delivered by the ICS to the national VPR standard. As the dashboard has not been fully implemented, the impacts are yet to be seen. However, the success of the dashboard will be assessed as follows:

1. Real-time monitoring enables timely responses and interventions.
2. Using data to predict trends will help organisations to anticipate and prepare for potential spikes in violent incidents.
3. Regional overviews and localised data by organisation will allow for tailored responses to specific needs.
4. The integration of police data will foster collaboration between healthcare and law enforcement to enhance overall community safety and patient care.
5. The inclusion of protected characteristics data would allow for a more in-depth analysis of disparities in violence and support focused interventions protecting marginalised groups.
6. Proactive use of the dashboard to support resourcing decisions and decisions for staff will demonstrate to staff that actions will be taken.

Implementation challenges:

The creation of the dashboard is a complex task that requires long-term focus, which could dishearten partners. Some organisations have not adopted a multidisciplinary, community-focused approach. Data recording quality and analytical capabilities of the dashboard also present challenges.

Capturing and collating data is important for providing a clear picture of incidents, to identify key trends and risk factors to enable interventions to be implemented to prevent and mitigate

against risks. However, underreporting of violence against healthcare staff is a global issue (Vento, et al., 2020). A recent systematic review (Spencer, et al., 2023) of reasons for underreporting provides recommendations for interventions that could mitigate underreporting at different levels of responsibility. The authors note that management have particular responsibilities for ensuring that culture and environment are supportive of reporting (Box 4).

Box 4. Management interventions to mitigate underreporting (Spencer, et al., 2023)

Create a Positive Unit Culture

- Display a caring, engaged, supportive, approachable, and nonjudgmental attitude.
- Create an environment of valuing nurses' input and a culture of preventing, recognising, reporting and addressing violence.
- Develop and enforce an open and blame-free culture around violence and reporting.
- Maintain effective communication with staff.

Follow up

- Investigate and address all reports of workplace violence promptly, consistently, and provide appropriate feedback in a debrief after a workplace violence event.
- Enforce workplace violence policies.

Collaboration

- Collaborate with interprofessional team and management.

Support

- Listen to staff and offer post-event support.
- Provide time for staff to formally report workplace violence.
- Guide staff to additional resources for assistance.
- Message the intolerance of workplace violence.

5.3.6.2 Restorative approaches

There are a growing number of examples of restorative practice being applied within public sector organisations, including the NHS (Parkinson, 2023). For example, theme three of the NHS Civility and Respect framework is about the adoption of a restorative and just culture approach. Within the NHS such practices are being used to target improvement cultures, staff wellbeing and to implement a 'Just and Learning' culture (Parkinson, 2023; Dekker, et al., 2022).

According to the European Forum for Restorative Justice, restorative justice is "an approach for addressing harm or the risk of harm through engaging all those affected in coming to a common understanding and agreement on how the harm or wrongdoing can be repaired and justice achieved". NHS North East and North Cumbria ICS are utilising a restorative justice approach in a pilot with a mental health and an ambulance trust within the ICS footprint as described in **Intervention case study 8**.

Intervention case study 8 – Restorative justice approach in NHS North East & North Cumbria ICS

Context and aims of the work:

The ICB is piloting the use of a restorative justice approach following incidents of violent, aggressive, or abusive behaviour enacted by patients to NHS staff. The approach aims to address and reduce all aspects of harm through conflict resolution, mediation and communication. The intervention is designed to address two specific problems in relation to a culture of underreporting of violent incidents:

1) Staff are reluctant to criminalise violence and aggression towards themselves, out of protectiveness towards their patients
2) Staff are reluctant to report incidents out of an assumption of inaction from management or law enforcement.

Intervention overview:

The ICB has created a three-stage training package aimed at line managers, which has the purpose of educating them about the restorative approach and to enable them to advocate for their employees in situations of physical or verbal violence. The training is targeted at line managers due to an observed lack of focus in previous prevention strategies on equipping management to support staff. Line managers are encouraged to adhere to the needs of their employees above all else, allowing them to take as much or as little action as the affected staff member is comfortable with. Overall, the restorative process holds the perpetrator accountable whilst not automatically criminalising their actions. It is a way of addressing the root causes of violent, aggressive or abusive behaviour and potentially finding a way forward from their actions.

The three stages involve:

1) Prior to any action, a conversation between the line manager and the affected staff member is held. Staff members are offered any immediate support they may need and are encouraged to report the incident and stay informed of any criminal proceedings that are necessary.
2) Staff can choose between face-to-face or shuttle mediation restorative approaches.
3) If the staff are reluctant to take further action, then they are empowered in this decision ("a positive decision to do nothing").

Intervention evaluation and impacts:

A pilot of the approach is currently running in a mental health trust and an ambulance trust. The expected benefits that would indicate the success of the approach are greater trust in management, staff members feeling empowered and benefits to patients.

Implementation challenges:

The restorative approach is not a quick fix and takes time, effort, and resources to implement successfully.

6 Discussion

Violence, harassment and abuse within the workplace are a pervasive global issue but critically, staff working in the healthcare sector are at increased risk. International evidence suggests the number of healthcare workers who experience workplace violence is three times higher than staff in other sectors (International Labour Organization (ILO), 2022) (Liu, et al., 2019). Concerningly, violence against healthcare workers greatly increased during the COVID-19 pandemic, and evidence suggests this upward trend has continued (World Health Organization, 2022; Brigo, et al., 2022). The World Medical Association declared violence against healthcare workers a healthcare emergency and called for WHO and member states to take action (The World Medical Association, 2020).

In 2020/21, the NHS People Plan was published with a strong emphasis on 'Looking after our People' – including 23 commitments related to health and wellbeing. One of the NHS People Plan promises is that all people feel supported, safe and secure at work. In addition, various national and NHS specific legislation and policies provide a strong impetus for multi-sectorial agencies to address violence following a whole system public health approach (e.g., Serious Violence Strategy). Leaders across the NHS have a statutory duty of care to prevent and control violence in the workplace – in line with existing legislation – so that people never feel fearful or apprehensive about coming to work. However, since NHS Protect was disbanded in 2016, there has been no national NHS wide data collection of incidents of violence, harassment and abuse towards NHS staff. This limits opportunities to fully understand its nature, extent,impact, and risk and protective factors, which can help inform more effective prevention and response activity. Yet even without this, the scale of the issues means there are a wealth of interventions and approaches to address violence, harassment and abuse towards staff being implemented at local, regional and national level. Understanding these approaches and interventions and how they relate to evidence on the issue is key to ensuring all people feel supported, safe and secure at work. Thus in 2022/23, NHS England commissioned the Public Health Institute, Liverpool John Moores University to conduct a desk-based review of work-based violence, harassment and abuse towards NHS staff in England.

6.1 Nature and extent

Evidence showed that the nature of violence, harassment and abuse which staff experience is varied and includes a range of different types, including physical assault and aggression; verbal aggression, abuse or threats; sexual abuse, aggression, and assault; discrimination and harassment; and bullying. In addition to direct experiences of violence, staff often witness their colleagues experiencing violence, harassment and abuse. Compared to other sectors, NHS staff may be at risk of a broader range of different types of violence, harassment and abuse at work (Nordin, 1995) and there are circumstances unique to NHS staff that increase their risk of a broader range of violence compared to other sectors (Reeves, 2000). For example, NHS staff are more likely to have prolonged contact with individuals, work alone with them, work in circumstances where individuals are distressed, or with individuals who have mental or psychiatric issues, are under the influence of substances, or have received

distressing news (Health Safety Executive, n.d.). In addition, staff were found to experience high levels of bullying and harassment by workplace colleagues, particularly by more senior staff and management. Inequality between victims and perpetrators is a key component of bullying (Health Safety Executive, n.d.). The, sometimes necessary, hierarchy of healthcare structures can foster and sustain bullying cultures and acceptability of bullying, increasing the likelihood of more junior and less experienced staff experiencing bullying.

Evidence on the extent of violence against NHS staff varies widely depending on context, organisation, job role, perpetrator, and the nature of violence examined, but overall evidence indicates a high level of incidence and prevalence of violence, harassment and abuse. National level data suggests there are as many as 200 assaults on staff per day (Royal College of Nursing, 2018; Cowper, 2023) and the NHS Staff Survey indicates that as many as one in seven NHS staff experience physical violence from patients, their relatives, or members of the public and one third have experienced harassment, bullying or abuse (NHS England, 2023). Violence, harassment and abuse are often not a one-off experience for NHS staff, with evidence suggesting it is commonplace and frequent (NHS England, 2023). Individuals who experience high frequencies of violence and repeated victimisation are at an increased risk of trauma-associated health issues including mental health problems and substance use disorders (Kilpatrick, et al., 1997; Arata, 1999; Mayhew, et al., 2004).

In line with global evidence, the current review found that violence, harassment and abuse against NHS staff has increased in recent years. However, whilst incidence data shows an increase in recent years, prevalence data from the self-report NHS Staff Survey demonstrated that levels of violence, harassment and abuse, have either remained approximately stable or decreased between 2018 and 2022. Understanding and investigating reasons for the disparity is an important area for future research. Some possible explanations for the disparity may include improvements in reporting and recording of incidents over time (which may increase incidence but not necessarily numbers of affected staff), or an increase in particular groups of higher risk staff experiencing violence (which would increase prevalence but not necessarily frequency).

It is crucial that staff are encouraged to report all incidents of violence, harassment and abuse. Concerningly, findings from the NHS Staff Survey suggest that a large proportion of staff who experienced some form of violence, harassment and abuse in the past 12 months did not report the incident (NHS England, 2023). This review identified several barriers to reporting including the acceptability of violence, the perception that even if reported no further action will be taken, a feeling of personal responsibility and skill inadequacy which may have contributed to the occurrence of the incident, and the burden involved in reporting an incident (particularly relating to existing high workload demands). Furthermore, research has shown a strong correlation between the reporting of incidents and staff satisfaction with the level of support they receive from their manager, which suggests that a positive working environment with strong management support is critical to encouraging reporting of incidents, responding to them appropriately and providing staff with support to reduce the negative impacts of the experience. Evidence also suggested a range of demographic and occupational factors were associated with reporting including sociodemographic factors (e.g., gender, age and ethnicity)

and occupational factor (e.g., occupation group, trust type, length of service and amount of patient contact). Further research is required to explore the reasons why particular groups are less likely to report incidents. Understanding the specific barriers to reporting for specific groups could help to inform interventions which aim to encourage reporting. Tackling the reasons for underreporting is critical. Without reliable data on violence, harassment and abuse against staff, the extent of the problem cannot properly be assessed and addressed.

Data reliability is important to understand the extent of the problem and good recording systems and data analysis of the data is key to assessing the issue. The end of national NHS wide data collection in 2016 means trusts and organisations have started collecting and organising data in different ways. This prevents comparisons between trusts and a national average against which to monitor the issue and the progress (or otherwise) of interventions. Evidence from this review suggests that there are differences between trusts in the level of detail recorded about incidents. Whilst it is important to consider the burden staff feel completing incidence forms (a barrier to reporting), sufficient detail about the nature of the incident and the characteristics of the perpetrator and victim are important to fully understand risk and protective factors and to inform the design of prevention activity. Trust-level data received as part of this review did not often disaggregate incident data by perpetrator and violence type, and in some cases, data was combined with violence against patient data to provide an overall summary of violent incidents. Lack of disaggregation of data prevents, for example, exploring the contexts and locations in which violence occurs which may differ based on whether it is lateral (i.e. perpetrated by patients, relatives, or other members of the public against staff) or horizontal (i.e. perpetrated by other staff against other staff), or whether violence, harassment and abuse is perpetrated by staff (or other patients) against patients. This will have implications for deciding which type of intervention activity to implement, which setting and at whom the activity should be targeted and what outcomes to measure whether it has been effective (or not).

6.2 Impacts

The global evidence on violence, harassment and abuse against healthcare workers suggests it has enormous costs for the individual ranging from the direct impacts of physical injuries (Nyberg, et al., 2021) to longer term psychological problems including PTSD, depressive symptoms, anxiety, burnout, and emotional impacts (Arnetz & Arnetz, 2001; Winstanley & Whittington, 2002; Atawneh, et al., 2003; Atan, et al., 2012; Richter & Berger, 2006). Evidence from this review confirms many of the findings, with the strongest evidence related to impacts on mental health. Around one in four frontline health professionals in England may experience emotional or psychological distress following an incident of verbal abuse or physical assault (Ipsos MORI, 2010). The impact of bullying by colleagues may be even more significant, with a study finding that almost one third of nurses experienced psychological distress following bullying incidents (Carter, et al., 2013). Although it is acknowledged that experiencing physical violence can leave staff with potentially long-term physical injuries, we identified a lack of evidence on physical health problems; this lack of evidence is also a feature of the international evidence base (Nyberg, et al., 2021).

The impact of violence, harassment and abuse on mental wellbeing and physical health can also contribute to organisational level impacts in the form of staff absenteeism and staff retention, with bullying and harassment directly impacting the retention of staff. However, most studies examined intentions to leave and there is a lack of evidence about the direct impacts on staff turnover. Sickness absence has been identified as a considerable burden to the NHS and the evidence reviewed draws links between experiences of violence, harassment and abuse and staff shortages due to staff taking sick leave. Critically, absences and staff shortages put increased pressure on the system, increasing stress and workload for remaining staff, and waiting times for treatment, factors which this review identified as key risk factors for violence, harassment and abuse, thus perpetuating the cycle. Furthermore, there are significant financial costs to the NHS associated with absenteeism and employee turnover.

Staff wellbeing at work is also impacted by experiences of violence, harassment and abuse. For example, bullying and harassment from managers or other colleagues can result in lower levels of job satisfaction and reduced levels of motivation and commitment. The evidence draws links between the impact of violence, harassment and abuse on the quality of care through its impacts on job satisfaction and motivation. However, evidence that shows a direct impact on quality of care is lacking. Critically, the review identified that the high prevalence and incidence of violence can lead to an increased acceptability and normalisation of violence at work (Sunley, 2018; Binmadi & Alblowi, 2019; Hunter, et al., 2022; Rivett & Wood, 2023). Such cultures of normalisation and tolerance can impact on levels of reporting if staff feel there is an expectation to accept abusive behaviour. Thus, the many and often severe impacts of violence, harassment and abuse against staff at individual and organisational level emphasise the need to urgently address the issue. Given current pressures and retention crisis in NHS, it is particularly critical to ensure staff have a safe and positive environment to work in.

6.3 Risk factors

The evidence shows that a broad system of factors contribute to both the occurrence of violence, harassment and abuse within the NHS and the impact that is experienced following incidents. Violence, harassment and abuse are often framed as being rooted in individual behaviours, and while this review highlights several individual level risk factors, the review also evidences a range of risk factors at the environmental/situational, organisation and societal level. It is important to recognise that systemic contributions are equally, if not more, important as many factors outside of the control of staff contribute to the risk of violence, harassment and abuse that they experience.

Individual (staff/patient) level risk (and protective) factors: Many studies identified 'staff-related factors' that are risk factors for experiencing work-based violence, harassment or abuse. These included professional position, length of experience and level of patient contact. The NHS, like other complex healthcare organisations, has a top-down structure of hierarchical and pyramidal management. Although hierarchies bring functional benefits for performance and decision-making, the resulting inequalities in status, authority and power can be linked to negative effects including bullying and discrimination (Essex, et al., 2023). The evidence reviewed suggests that nurses, healthcare support workers, and students are more

likely to experience violence, harassment and abuse from patients compared to more senior members of staff and staff members perceived as having more seniority are more likely to perpetrate bullying. Evidence also suggests that bullying and discriminatory behaviours can filter down through the hierarchy. Hierarchy influences how teams operate and can results in gender and ethnic inequalities being reproduced within the health workforce. As noted, staff from ethnic minority groups are more likely to experience violence, harassment and abuse than their White colleagues.

High workloads, feeling overworked and stressed were also identified as risk factors for violence, harassment and abuse. Stressed and overworked staff may struggle to defuse violent situations, and managers, in particular may also perpetuate bullying behaviours due to frustration with others' performance. Workloads and stress can lead to patient frustration, contributing to violent incidents. Equally, violence, harassment and abuse within the workplace, can in turn cause stress and anxiety among staff, potentially leading to more employees leaving, exacerbating stress levels in the workplace, and increasing the risk of violence.

At the patient-staff level, ‘good’ communication was identified as a protective factor, with the use of both verbal and non-verbal communication skills identified as important. Communication between staff was also important. Related to the underreporting of violence, harassment and abuse, evidence suggests that many NHS workers see violence as an inherent part of their job that they must tolerate. Studies provided examples of staff and students underreporting incidents due to a reluctance to be seen as ‘trouble makers’. This also links back to evidence suggesting that staff can feel isolated following incidents of violence, harassment and abuse.

At the perpetrator level, particular behaviour and characteristics among patients have been found to be risk factors for violence, harassment and abuse. These factors include alcohol and substance use-related issues, brain injury and mental health/psychiatric conditions. Patients with a history of violence are also more likely to perpetrate violence. Other factors that contribute towards a risk of violence, harassment and abuse from patients and their relatives includes waiting time and delays and expectations about care. Again, taken together these findings suggest that many factors outside of the control of staff contribute to the risk of violence, harassment and abuse from patients and their relatives.

Environmental/situational risk factors: Several environmental and situational risk factors were identified. Critically, long waiting times are a major risk factor for violence, harassment and abuse, particularly verbal and physical abuse. The design of healthcare environments also influences the likelihood of staff experiencing violence, harassment and abuse from patients. Poor environmental design factors may increase the likelihood of violence, harassment and abuse. Lone working is also a risk factor for experiencing violence, harassment and abuse. Staff who work alone, such as community-based staff, delivery drivers, health visitors, and others, may be at an elevated risk as they lack immediate assistance to manage conflict or respond to situations involving known violent individuals.

Organisational and societal risk factors and influences: Insufficient policies and ineffective management have been identified as significant factors contributing to the risk of violence, harassment and abuse in healthcare settings. Strong leadership across the system is vital to ensure that violence, harassment and abuse is considered in policies and practices across the healthcare system, that prevention efforts are effectively implemented and coordinated, and staff are protected from harm. However, several organisational and societal factors pose challenges for preventing violence, harassment and abuse. For example, financial deficits in healthcare organisations may correlate with an increase in violent assaults. Financial struggles may lead to staff shortages, longer patient waiting times, and increased stress for both patients and staff. These pressures on patient services may be contributory factors to the rise in incidents of violence, harassment and abuse.

The evidence indicates that there has been an increase in violence, harassment and abuse towards NHS staff working in emergency departments and the ambulance service following the COVID-19 pandemic. It is recognised that the COVID-19 pandemic has exacerbated pressures on healthcare systems around the world because of challenges from workforce shortages and with recruitment and retention. However, the NHS has experienced other long-standing issues that continue to place pressure on the system and the ability to provide high quality care. These external influences are part of the wider system of factors within the NHS that are a background to incidents of violence, harassment and abuse.

6.4 Prevention and response

There is broad agreement that integrated approaches are required to ensure that organisational responses to violence, harassment and abuse are effective and sustainable. For example, the ILO, WHO, PSI and ICN recommend that interventions and approaches include multiple components including training, security measures and structured workplace violence prevention and management policies. The complex and interacting factors involved in responding to violence, harassment and abuse within the NHS will not be solved through improvement strategies that are simple and linear. Isolated changes within the healthcare system are unlikely to be sustainable. The complex and multifactorial nature of work-based violence, harassment and abuse has led researchers to explore responses through systems thinking-related models and methods (Salmon, et al., 2022; Sheppard, et al., 2022). Rasmussen's risk management framework (Rasmussen, 1997) has been particularly influential among researchers working in the field of safety science (Box 5).

Box 5. Considerations for implementing a 'systems thinking' approach to preventing and responding to violence, harassment and abuse

1. Work-related violence is an emergent issue impacted by the decisions and actions of all actors, not just healthcare workers, patients, family members and security staff alone.
2. Work-related violence is caused by multiple contributing factors from across hospital systems, not just a single poor decision or action at the sharp end.
3. Work-related violence can result from a lack of poor communication and feedback (or 'vertical integration') across levels of hospital systems, not just from deficiencies at one level alone.
4. Lack of vertical integration is caused, in part, by lack of feedback across levels of hospital systems.
5. Behaviours within hospital systems are not static, they migrate over time and under the influence of various pressures such as workload, financial, societal, and psychological pressures.
6. Migration of behaviour occurs at multiple levels of hospital systems.
7. Migration of practices cause hospital system defences to degrade and erode gradually over time, not all at once. Work-related violence incidents are caused by a combination of this migration and a triggering event(s).

Adapted from Rasmussen's framework by Salmon et al. (Salmon, et al., 2022)

The case studies evidenced several considerations to inform a whole systems approach to preventing and responding to violence, harassment and abuse. The importance of legislation and local level policies was raised often. Alongside strong leadership to ensure implementation, legislation and policies are both an important tool for raising awareness among the workforce and a strong prerequisite to enabling shifts in culture and ensuring that prevention is adequately resourced. Multidisciplinary collaboration was also an important feature of effective implementation and delivery of violence prevention interventions and approaches. The interventions and approaches highlighted within the case studies revealed that there is a shared vision and common aim to create a culture shift by creating safer work environments and empowering staff to have the confidence and the means to report violence, harassment and abuse. However, there was also evidence of a "crowded marketplace of interventions",and it was perceived that a consistent approach to the delivery of this vision was lacking. The evidence base has tended towards the evaluation of single component approaches but in general, a robust evidence base is lacking to inform decisions about the types of interventions and approaches that should be implemented. Applying a systems thinking approach, which places an emphasis on understanding the whole system, may help to identify areas of common intervention that bring consistency to responses whilst still allowing for diversity in the approaches delivered based on local and hyperlocal understandings of need. A key implication of applying a systems thinking-related approach to violence, harassment and abuse towards NHS staff is that the influence of pressures and issues at higher levels of hospital systems are considered (Salmon, et al., 2022). Pressures related to resources and funding are both an external influence and important contributory factors for violence, harassment and abuse but they also have a direct impact, for example,

when funding for interventions and programmes is withdrawn. Systems thinking approaches also create space for national policies to be incorporated more systematically into local responses. For example, the national focus on trauma-informed policy and practice is evidently informing responses detailed in the case studies but there is a need to avoid piecemeal implementation within other areas and settings.

7 Recommendations

Based on the evidence reviewed, violence, harassment and abuse in the NHS is best recognised as a complex and multifactorial issue with contributory factors spanning different levels of the healthcare system and beyond the system in the form of external influences. There are many causal pathways which are likely to influence the occurrence of violence, harassment and abuse within NHS settings and bringing a systems thinking lens may provide a basis on which to move forward with the development of sustainable organisational responses.

1. Building on existing (and future) UK Government and NHS violence prevention policy and governance and practice implementation systems, NHS organisations and ICBs should provide leadership to encourage and support the adoption and implementation of an evidence-based whole system public health approach to violence prevention (covering staff, patients and the wider community across the ICS footprint).
2. NHS England should provide national support and coordination, including guidance and evidence on whole systems approaches to addressing violence, harassment and abuse across healthcare settings, and enable NHS organisations and ICBs to deliver bottom-up flexible approaches to implementation, that is informed by and meets the needs of the local community and setting.
3. NHS organisations and ICBs should explore and evidence the implementation and impacts of the VPR standard, identifying key lessons for implementation and areas for developing the use and value of the standard. NHS England should continue work with NHS organisation and ICBs to roll out the VPR standard.
4. To support the meaningful comparison of local/regional data on violence, harassment and abuse across healthcare settings (and in the ongoing absence of a national data collection system), NHS England should develop guidance for NHS organisations and ICBs including common definitions of violence, harassment and abuse towards NHS staff, standardised methods for data collection and recommended data fields.
5. NHS England should identify opportunities to develop and implement a national system for the collection, analyses and dissemination of data on incidents of violence, harassment and abuse towards NHS staff. The system should enable an increased understanding of the nature and extent of violence, and its consequences, across groups and settings, and risk and protective factors, to inform the development, implementation, and monitoring/evaluation of prevention approaches.
6. NHS England should work with NHS organisations and ICBs to create a culture of rejection and of taking action on violence, harassment and abuse within the NHS, including amongst patients but critically across staff. NHS organisations and ICBs should ensure that experiences of violence are not accepted as part of the job, encourage reporting by developing and enforcing an open and blame-free culture, and guide staff towards engagement with support services.

7. NHS England, NHS organisations and ICBs should bring the NHS workforce community together and provide support for them to share their experiences of violence and prevention approaches at local, regional and national level (e.g., national conference on violence towards NHS staff).
8. NHS England, NHS organisations and ICBs working with the Unions and through staff networks should ensure that policies and approaches to preventing and responding to violence, harassment and abuse are developed through closer partnership working with representatives across different sectors and groups of the workforce.
9. Working with wider partners, NHS England, NHS organisations and ICBs should develop and/or identify opportunities to robustly evaluate the impact of interventions to prevent and respond to violence against healthcare staff. This may include working with independent evaluators to design evaluation and implementation plans (including logic models/theories of change) for interventions that can/are being implemented at scale (e.g., across healthcare sites/settings) and applying for national research council funding (e.g., National Institute for Health Research) and/or working with partners to identify other research and evaluation funding opportunities (e.g. via local/regional networks/partners such as Violence Reduction Unit's, police, health and social care).
10. Where robust and/or independent evaluation is not feasible or appropriate, NHS systems should work together to develop minimum standards for monitoring and/or evaluation of interventions including guidance around evaluation. This should include consideration of evaluating interventions at different levels e.g. local, regional and systems levels. Reference should also be made to reporting and dissemination of evaluation findings, which may be supported through, for example, communities of practice or workforce research forums to share learning.

Further research recommendations

Fill gaps in current knowledge and evidence identified through this review by carrying out further research, specifically:

- Carry out research to improve understanding of the causes of violence against staff, with specific attention to the staff groups and demographics of those most at risk of violence to design and target appropriate interventions more effectively. Implementation of more robust data collection mechanisms on violence against staff which record occupational and demographics data in incidents of violence against staff and which can be disaggregated to identify at risk groups would support this type of research. This might be done through existing data collection and recording systems, for example, equality impact assessments or the NHS survey.
- Carry out research to enhance understanding of the impacts of violence on NHS staff and staff views on what they require from prevention activity, to ensure approaches keep them safe and healthy.
- Carry out research on, and evaluation of, restrictive interventions in non-mental health settings, particularly emergency departments and within the ambulance service.

- Carry out research to explore formal risk assessment practice across NHS settings to enhance understanding of the role of risk assessment practice and approaches in identifying and anticipating risks that may lead to violence, harassment and abuse towards NHS staff.

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Appendices

Appendix 1: Methodology

Systematic literature review

Searches of bibliographic databases, supplementary searching and grey literature were undertaken to identify the existing national and international evidence and expert opinion regarding:

- Factors and processes that influence work-based violence, harassment and abuse.
- Organisational responses to work-based violence, harassment and abuse.

Literature searches for published literature were done in Medline, Cinahl, PsycInfo and Social Sciences Citation Index (Web of Knowledge) Web of Science in September 2022 to identify relevant studies published since 2000. A search strategy was developed and adapted for each database using a combination of free text and database index terms. The strategy for Medline is provided below and this was adapted for use with the other databases. Searches for the grey literature were also carried out by targeted searching in Google, Google Scholar and key organisational websites.

#	**Search terms**
1	(TI (violen* OR abus* OR attack* OR assault* OR batter* OR beat* OR threaten* OR aggressi* OR incivil* OR harass* OR bully* OR bullies OR crime OR hostil* OR rude* OR unkind* OR torment* OR aggravat* OR intimidate* OR provocation OR provoke* OR insult* OR hassl* OR oppress* OR supress* OR violat* OR maltreat* OR mistreat* OR cyberbully*)) OR (AB (violen* OR abus* OR attack* OR assault* OR batter* OR beat* OR threaten* OR aggressi* OR incivil* OR harass* OR bully* OR bullies OR crime OR hostil* OR rude* OR unkind* OR torment* OR aggravat* OR intimidate* OR provocation OR provoke* OR insult* OR hassl* OR oppress* OR supress* OR violat* OR maltreat* OR mistreat* OR cyberbully*))
2	(MH ("Violence" OR "Bullying" OR “Crime” OR “Physical Abuse” OR “Sex Offenses” OR “Exposure to Violence” OR “Aggression” Or “Cyberbullying” OR "Agonistic Behavior" OR “Incivility” OR “Emotional Abuse” OR “Torture”))
3	S1 OR S2
4	(TI ("work environment" OR workplace* OR worksite* OR occupational OR employee*)) OR (AB ("work environment" OR workplace* OR occupational OR employee*))
5	(MH ("Workplace" OR "Employment" OR "Personnel Management" OR "Personnel Administration, Hospital" OR "Interprofessional Relations" OR "Organizational Culture" OR "Employee Discipline"))
6	S4 OR S5
7	S3 AND S6
8	(MH ("Workplace violence"))
9	S7 OR S8
10	(TI (health OR healthcare OR "health care" OR medical) N1 (worker* or professional* or provider* OR staff OR personnel OR employee* OR assistant* OR practitioner*)) OR (AB (health OR healthcare OR "health care" OR medical) N1 (worker* or professional* or provider* OR staff OR personnel OR employee* OR assistant* OR practitioner*))
11	(MH ("Health Personnel+"))
12	(TI (hospital* OR prehospital OR healthcare OR "health care" OR "health service*" OR NHS OR inpatient OR outpatient OR "acute care" OR ambulance* OR ambulatory OR "emergency department" OR "intensive care" OR "primary care" OR "secondary care" OR "tertiary care" OR hospice* OR "care home*" OR "nursing home*" OR "assisted living" OR nurse* OR nursing OR physician* OR doctor* OR midwif* OR

	psychiatr* OR pharmac* OR surgery OR surgeon* dental OR dentist* OR physiotherap* OR radiograph* OR paramedic* OR "general practice*" OR "general practitioner*" OR GP OR psycholog* OR optometr* OR anaesthet* OR audiolog* OR gynaecolog* OR obstetric* OR "occupational therap*" OR paediatric* OR pediatric* OR podiatr* OR chiropod* OR porter*)) OR (AB (hospital* OR prehospital OR healthcare OR "health care" OR "health service*" OR NHS OR inpatient OR outpatient OR "acute care" OR ambulance* OR ambulatory OR "emergency department" OR "intensive care" OR "primary care" OR "secondary care" OR "tertiary care" OR hospice* OR "care home*" OR "nursing home*" OR "assisted living" OR nurse* OR nursing OR physician* OR doctor* OR midwif* OR psychiatr* OR pharmac* OR surgery OR surgeon* OR dental OR dentist* OR physiotherap* OR radiograph* OR paramedic* OR "general practice*" OR "general practitioner*" OR GP OR psycholog* OR optometr* OR anaesthet* OR audiolog* OR gynaecolog* OR obstetric* OR "occupational therap*" OR paediatric* OR pediatric* OR podiatr* OR chiropod* OR porter*))
13	(MH ("Hospitals+" OR “Residential Facilities” OR “Rehabilitation Centers” OR “Pharmacies” OR “Tertiary Care Centers” OR “Secondary Care Centers” OR “Mobile Health Units” OR “Hospital Units” OR “Fertility Clinics” OR “Dental Facilities” OR “Ambulatory Care Facilities” OR “Academic Medical Centers”))
14	S10 OR S11 OR S12 OR S13
15	S9 AND S14

Call for evidence

The call for evidence invited stakeholders to submit evidence on (i) the nature, extent, impacts and consequences of violence, harassment and abuse towards NHS staff; and (ii) prevention and management of violence, harassment and abuse, including current and planned system-level or organisational responses. A dedicated email inbox was set up to receive information and the call was launched at the Preventing Violence Against Staff network meeting on 29th March 2023. Three subsequent calls for evidence and reminders were sent out during Summer 2023. Any reports received through the call for evidence were examined for relevance against the same criteria used for the systematic literature review.

Case study development

Consultation discussions were conducted with stakeholders who responded to the call for evidence and agreed to speak with the LJMU team in more detail. The purpose was to gather further information about the aims, objectives and intended outcomes of activities in NHS organisations which are tackling workplace violence, harassment and abuse. A discussion guide was developed to ensure that questions were focused on key areas of interest for developing the case studies including, facilitators and barriers to delivery, main outcomes and details about evaluation.

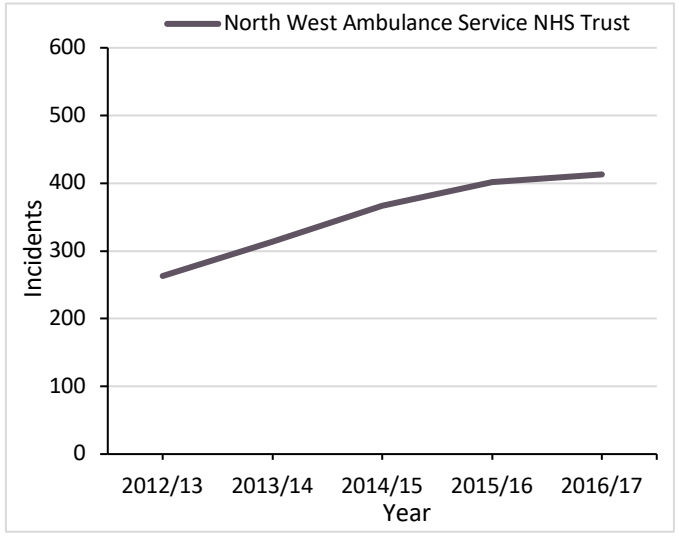
Appendix 2: Supplementary tables and figures

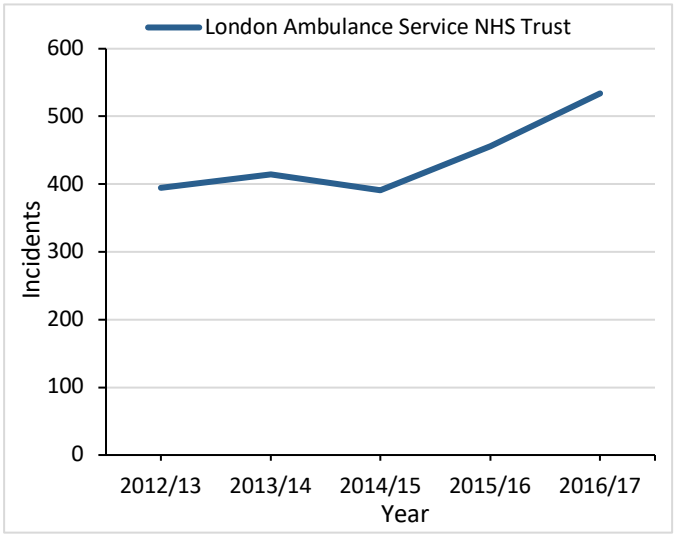
Table A2.1: Prevalence of experiencing violence, by demographics, occupational factors, perpetrator, and violence type, 2022 NHS Staff Survey table (NHS England, 2023)

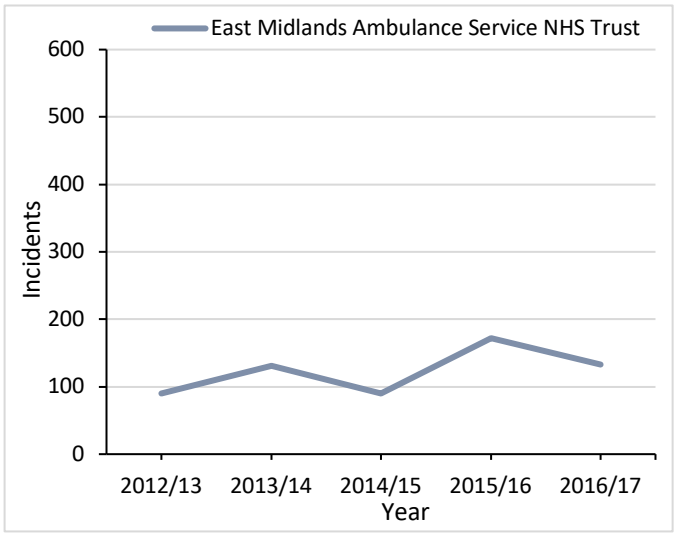
		Physical violence				Harassment, bullying, or abuse			
		Patients, relatives, members of the public	Manager	Other colleagues	Reported	Patients, relatives, members of the public	Manager	Other colleagues	Reported
All		14.7	0.8	1.8	72.4	27.8	11.1	18.7	49.7
Gender	Male	15.7	1.0	2.2	71.0	26.0	12.0	17.3	43.8
	Female	14.2	0.7	1.6	73.1	27.9	10.3	18.6	51.6
	Non-binary	21.1	3.8	5.6	63.1	37.3	20.2	29.7	43.0
	Prefer to self-describe	18.4	4.4	7.4	70.9	34.4	21.9	31.1	49.1
Age	16-20	22.0	0.9	2.2	73.2	30.2	7.1	17.1	56.1
	21-30	21.5	0.7	1.7	71.4	32.1	8.2	17.2	51.3
	31-40	16.9	0.8	1.9	72.3	28.2	10.2	19.1	50.5
	41-50	13.7	0.8	1.9	73.3	27.1	12.1	19.8	49.6
	51-65	10.5	0.7	1.6	72.7	25.7	12.2	18.2	48.5
	66+	7.2	0.9	1.7	71.8	20.7	9.4	13.4	47.9
Length of service	Less than 1 year	12.4	0.5	1.4	67.0	21.4	5.9	15.4	46.6
	1-2 years	17.3	0.8	1.9	71.9	29.0	8.9	19.4	51.6
	3-5 years	17.2	0.8	2.0	73.6	30.1	11.2	19.7	51.6
	6-10 years	15.7	0.8	1.8	73.5	28.7	12.2	19.1	50.8
	11-15 years	12.8	0.8	1.7	72.2	26.3	12.4	18.5	48.6
	>15 years	12.1	0.8	1.6	73.0	27.3	12.5	18.5	47.9
Patient facing role	Frequent contact	19.0	0.8	1.9	72.6	35.7	11.3	19.8	50.3
	Occasional contact	5.5	0.6	1.5	73.3	14.9	11.4	18.5	48.1
	No contact	4.8	0.7	1.5	70.5	7.7	9.8	14.6	46.8
Occupation group	Allied Health Professionals/Healthcare Scientists/Scientific & Technical	9.2	0.5	1.1	65.1	21.3	9.1	16.1	47.1
	Ambulance (operational)	37.1	1.4	2.5	73.6	52.1	15.1	19.2	45.8
	Medical & Dental	12.3	0.6	1.0	53.5	35.5	14.7	22.9	32.3
	Nursing & Healthcare Assistants	36.6	1.7	4.0	78.0	39.5	9.1	21.6	60.2

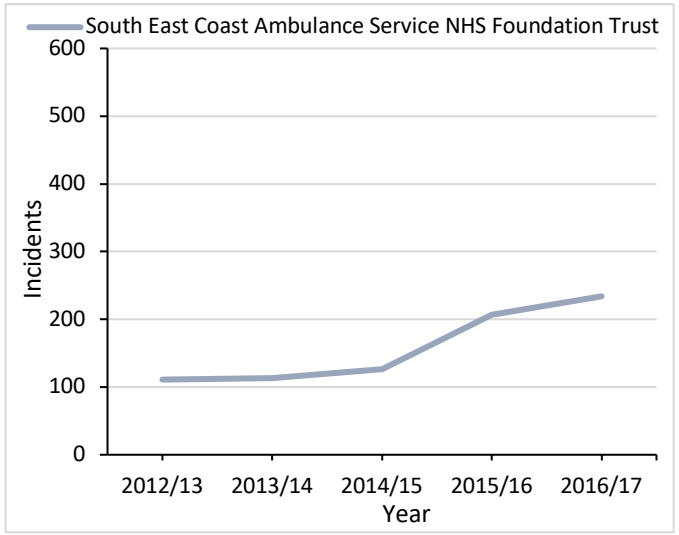
		Physical violence				Harassment, bullying, or abuse			
		Patients, relatives, members of the public	Manager	Other colleagues	Reported	Patients, relatives, members of the public	Manager	Other colleagues	Reported
	Registered Nurses & Midwives	23.4	1.0	2.3	75.2	38.5	12.5	22.4	53.7
	Social Care	10.8	1.0	1.9	84.3	27.6	9.4	15.1	58.6
	Wider Healthcare Team	2.9	0.5	1.1	69.1	15.1	9.6	14.4	48.4
	Other	5.4	0.7	1.6	71.3	14.5	11.6	17.5	50.1
Trust type	Acute and Acute & Community	14.5	0.9	1.9	68.0	27.8	11.7	20.0	47.4
	Acute Specialist	5.5	0.6	1.4	72.4	19.2	10.6	18.7	50.2
	Ambulance	14.2	0.5	1.3	89.4	26.2	8.7	14.5	60.5
	Community	7.3	0.4	0.7	75.0	21.6	7.6	12.8	57.5
	Mental Health & Learning Disability; Mental Health, Learning Disability & Community	30.5	1.2	2.1	73.9	44.8	14.8	18.5	46.0

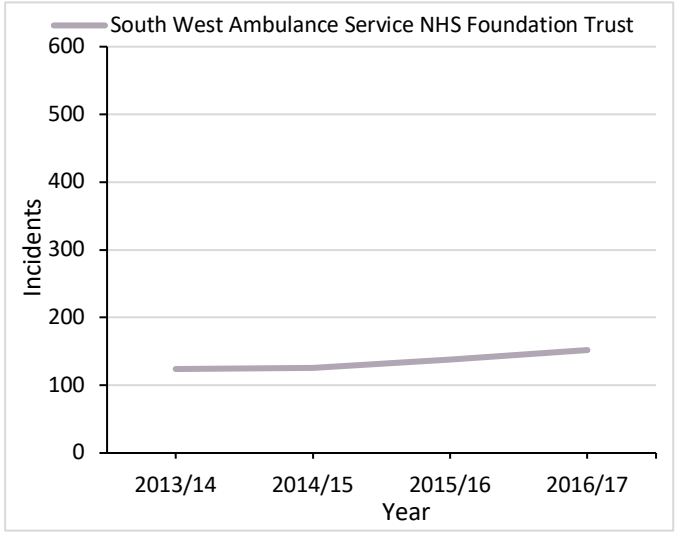
Figures A2.2: Physical assaults against ambulance workers in England, by year and ambulance trust (GMB Union, 2018)

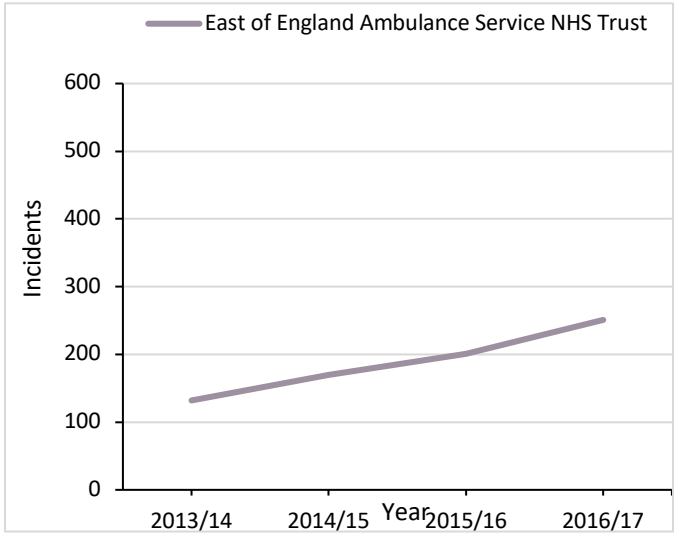


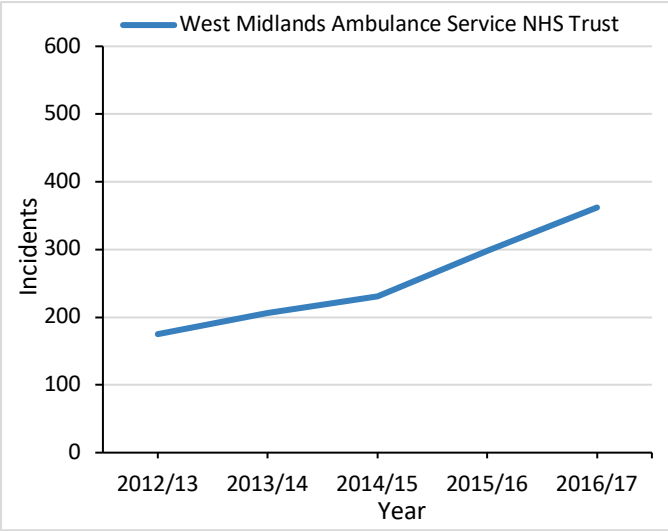


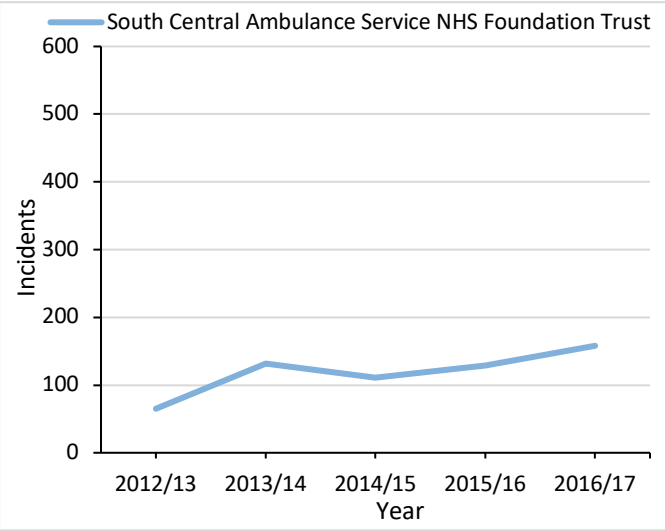


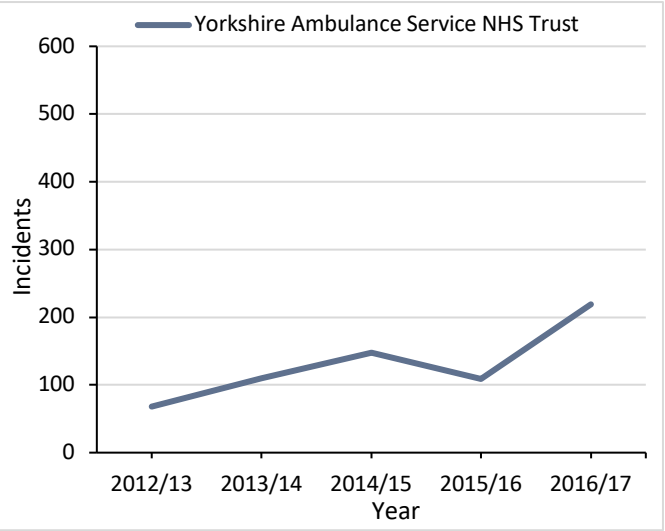







West Midlands Ambulance Service NHS Trust
600
500
400
300
200
100
0
Incidents
2012/13
2013/14
2014/15
2015/16
2016/17
Year


South Central Ambulance Service NHS Foundation Trust
600
500
400
300
200
100
0
Incidents
2012/13
2013/14
2014/15
2015/16
2016/17
Year


Yorkshire Ambulance Service NHS Trust
600
500
400
300
200
100
0
Incidents
2012/13
2013/14
2014/15
2015/16
2016/17
Year