Ipsos MORI

Violence against frontline NHS staff

Research Study Conducted for COI on behalf of the NHS Security Management Service

24 June 2010

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Background

In 2004, Ipsos MORI carried out a baseline survey to help the NHS Security Management Service to understand staff perceptions of workplace safety and incidents of violence at the time, and to allow them to track changes in future surveys.

In 2009 the NHS Security Management Service commissioned a follow-up study, to assess whether this picture had changed over time. They were keen to measure the progress the service has made over this 5 year period in establishing a 'pro-security culture'.

Aims and Objectives

The overall aim of this research was to enhance the NHS Security Management Service's understanding of the ways in which NHS frontline staff experience violence from the public and patients. This is so it is better placed to respond to these challenges with effective and efficient preventive measures.

The research captured information about both verbal abuse and verbal threats towards staff, as well as incidents of physical violence.

Methodology

The results of this study are based on 2,202 telephone interviews with frontline health professionals working for NHS organisations in England.

Summary of Findings

A 'Pro Security' Culture

The NHS pro-security culture has been strengthened since the 2004 survey, with an increase in recognition of the support provided by employers

- **Seven in ten** staff - a significant increase on the 2004 findings – agree that their **workplace provides a safe and secure working environment** against **verbal abuse** or **verbal threats** of physical violence from the general public and patients.

- The **vast majority** of staff – over nine in ten – **feel secure when they are working alone**. Among the small proportion who feel less secure, these are most likely to be midwives, security staff and A&E nurses, as well as those who have been physically assaulted in the workplace in the last twelve months.

- In terms of **physical violence**, three in four staff agree that **their workplace provides a safe and secure working environment** against this. These findings also show a significant increase in agreement since the 2004 benchmark research.

- A&E staff, nurses and those working in acute care are some of the groups more likely than average to disagree that their workplace provides a safe and secure environment.

Those who have attended CRT demonstrate increased awareness of other NHS SMS initiatives, as well as a greater awareness and a more positive attitude towards additional NHS security initiatives

- **One in four** staff have **attended CRT in the last year**, with roughly the same proportion having attended it between one and three years ago.

- As not all roles will have access to CRT, it is perhaps worth considering the other characteristics of non-attendees. **Men**, **staff of an Asian ethnicity** and those who have **been in their roles for less than a year** are all more likely than the overall average to have **never attended CRT**.

- This is also the case for those in **primary care** (where CRT is not mandatory among certain professions such as opticians) and **mental health organisations** (who attend tailored 'Promoting Safer and Therapeutic Services' training).

- This explains why **attendance at CRT is significantly higher among those in acute care** – more staff in acute care are required to attend this training.

Staff Awareness of NHS Security Policies and Initiatives

Staff awareness of specific NHS Security Management Service policies and initiatives varies greatly

- The NHS Security Management Service initiatives that staff are **most aware** of include **CRT**, **Local Reporting procedures** (PARS) and **Local violence/security/lone-worker policies and procedures**.

- Awareness of the initiatives benchmarked in the 2004 survey – CRT, LSMS and the Legal Protection Unit (LPU) – have all increased. However, while **awareness of CRT has increased significantly**, awareness of LSMS has increased to a lesser extent. Awareness of the LPU has also only grown in moderate terms.

Alarms, guards and mobile phones are recognised as support mechanisms provided by NHS employers

- Although cited by a relatively small proportion of staff, **other fixed emergency alarms**, **security guards/officers** and **mobile phones** are the three most mentioned support mechanisms/initiatives provided by employers. This is in addition to those provided by the NHS Security Management Service.

- Compared to the overall average, **practice nurses and managers** are more likely to mention **other fixed emergency alarms**, while **A&E staff** are more likely to say their workplace provides **security guards/officers.**

Lone worker policies, training and reporting procedures are making staff feel more secure in their place of work

- In terms of which initiatives and/or support mechanisms have made staff feel more secure in their place of work, the majority of **top mentions are from the prompted list of NHS Security Management Service initiatives**.

- **Local violence/security/lone worker policies and procedures**, **CRT** and **PARS** are the most mentioned, while **security guards/officers** and **mobile phones** were the most mentioned of those **additional mechanisms/initiatives** provided by employers.

- In descending order, **CRT**, **PARS** and **Local violence/security/lone worker policies and procedures** are also the three initiatives that staff know **a lot/a fair** amount about.

How Frontline NHS Staff Experience Violence

Overall, fewer staff are experiencing verbal abuse and physical assault in the workplace compared to 2004

- **One in three** staff say they have been **verbally abused or verbally threatened by a patient** in the last 12 months, followed by approaching **one in five** who say they

have been **verbally abused or threatened by a member of the public** (not a patient).

- Positively, when compared to the 2004 findings, there has been a significant **increase in the proportion** who say they have **not experienced any types of abuse** in the last twelve months, although **more have experienced multiple incidents** of physical abuse.

- The findings on the number of staff who have experienced physical assaults are broadly in line with the Care Quality Commission NHS staff survey, with five per cent of staff saying they have experienced a physical assault by a patient/service user in the 2009 NHS Security Management Service research compared to eight per cent who said this in the 2009 Care Quality Commission staff research[1].

Of those staff who are experiencing abuse, the frequency of verbal abuse experienced remains consistent with the 2004 findings, while the frequency of physical assaults has increased

- While there has **not been a significant decline in the frequency of verbal abuse** experienced by staff, this is in the context of an **overall fall** in the number of staff who say they have experienced verbal abuse.

- The findings on the frequency of physical assaults experienced by staff are somewhat different. Among the benchmark staff groups, a **notably higher proportion say they have been physically assaulted** on 6-10 occasions, while significantly fewer say they have been assaulted on one occasion[2].

Staff are more likely to be adversely affected by incidents of physical (rather than verbal) abuse

- The **majority of staff** – over three in five – **say they have not been affected** following incidents of verbal abuse or verbal threats of violence. This falls to just fewer than two in five among those staff who have experienced incidents of physical assault.

[1] Comparisons between the NHS Security Management Service research and the Care Quality Commission staff research should be treated as indicative. This is due to the methodological and question format differences between the two surveys.
[2] These trends should be treated as indicative due to the small base size of the 2004 research.

- Of those who **have been affected** by verbal abuse or physical assault, around one in four say they have **experienced emotional and/or physical distress**.

- For those who have **experienced physical assault**, the second most cited consequence is a **short-term physical injury** followed by having **learned more about personal safety** through the NHS.

Potential Causes, Triggers and Exacerbating Factors

Staff role, demographic characteristics and environmental factors all have an influence on the likelihood that staff will experience a type of abuse

- Approaching four in ten (37%) staff say they have experienced verbal abuse or verbal threats in the workplace. However, this is **more likely among certain staff groups** – particularly those in **A&E**, **security**, **nursing** and **complaints** roles.

- Time of day appears to have an effect on likelihood of abuse occurring, with those **staff working both day and night more likely to have experienced verbal abuse** compared to those just working during the day.

- Of the one in twenty staff who have experienced a **physical assault in the workplace**, this is most likely to involve staff working in **A&E**, **nursing** and **security roles,** with **hospital/inpatient nurses** and **security staff** the two groups that appear to be at particularly high risk.

- Additionally, it is **younger staff aged 16-24** and **male staff** who are more likely than average to experience physical assault in the workplace.

- **Time of day appears to have an impact** on the likelihood that a member of staff will experience a type of abuse, but over **two in five of those staff who work both day and night** say that verbal abuse and physical assault are likely to occur 'in equal measure day and night' – the largest response for each respectively.

- **Environmental factors appear to have an influence** on whether staff are more likely to experience violence in the workplace. **Staff are less likely to experience verbal and physical abuse** when factors such as noise, the number of people in close proximity, the working temperature and availability of seating are considered to be **good rather than poor**.

- However, some **factors appear to have less influence** – the availability of refreshments, CCTV coverage and the provision of smoking areas.
- Among those staff who have experienced abuse, the main contributory factors they perceive to be the cause include:
    - A consequence of the patient's **mental health condition**
    - The person was under the **influence of alcohol**
    - The length of time **waiting to be seen** by a health professional
    - **Problems understanding** information/instructions

Reporting Violence

Non-reporting of incidents is an issue for the NHS, with many staff saying that they are used to abuse/abuse is part of their job

- A **significant number of staff are not reporting** the incidents of verbal abuse or physical assault that they have experienced (over one in three and one in five respectively).
- Roughly **half the proportion** who have **reported an incident of physical assault** have **reported an incident of verbal abuse**.
- Two in three say they reported incidents to a manager, followed by one in five to LSMS and one in six to the police. **One in four staff have not reported any incidents** they have experienced.
- The main reason why staff **have not reported all the incidents of verbal abuse** in the last twelve months is that they are **used to it/part of the job**, which indicates that a significant proportion of NHS staff appear to **accept verbal abuse** as something they are likely to experience in the workplace.
- Additionally, over one in four of non-reporters say they **did not report** an incident because the **situation was resolved/not serious enough**.
- Only a **small number of staff are not reporting incidents of physical assault** – a reflection of how serious these incidents are generally perceived to be.

The patient's clinical condition and sympathy for the patient or their relative are the main reasons for non-reporting

- **Among those who have not reported** an incident, the main reasons are that the incident was a result of the **patient's clinical condition**, followed by **sympathy for the patient or a relative** and **the situation was resolved/not serious enough.**

The majority of staff say incident reports are easy to complete

- In terms of **completing incident reports** the **majority of staff** – over seven in ten – say they are **very/fairly easy to complete** for incidents of verbal abuse and physical assault.

- However, **one in ten** staff say that incident reports are **very/fairly difficult to complete** – a minority that cannot be ignored if translated into the wider frontline NHS workforce.

Staff tend to be positive about the reporting processes and the action taken to deal with reports for both verbal and physical abuse, but their concern is with reporting outcomes

- Over seven in ten agree that the **NHS has an effective process for reporting incidents of verbal abuse**, including threats of physical violence, and nearly eight in ten agree it has an **effective process to report incidents of physical abuse**.

- Two in three agree the **NHS takes the appropriate action** to deal **with reports of physical abuse**, while approaching two in three say the NHS takes the **appropriate actions** to **deal with reports of verbal abuse**, including threats of physical violence.

- However, **significantly fewer staff (less than half) agree** that reporting an incident of physical or verbal abuse **leads to a satisfactory outcome**

- **Insufficient penalties for the offender** and **inadequate communication from a manager** (one in five for both respectively) are the main reasons cited among staff who disagree that reporting an incident of abuse leads to a satisfactory outcome. **Nothing gets done** is also a top mention.

- It is important for the NHS Security Management Service to **address these concerns** if the number of staff who are **apathetic towards the reporting process** are to be reduced.

Improving Safety

Increased security and a quicker response to incidents are considered to be the priorities for security improvements

- One in five staff say **nothing/already safe/continue the good safety standards** when asked about their priorities for making their workplace a safer and more secure working environment – the largest single response.
- Many additional reasons are cited by staff on how security could be improved. Of the suggested priorities, the **most commonly mentioned** are:
    - Increased security/quicker response
    - Safety of staff/patients/public
    - Training/education of staff
    - More CCTV/cameras
    - Tracking staff/single worker safety
- There are **no specific themes linking these priorities**, rather staff indicate **a range of approaches** to make their workplace more safe and secure.
- It is evident that there is **no 'quick win' for increasing the perception of safety and security in the workplace** among frontline NHS staff, just as there is no immediate solution for tackling the actual levels of verbal abuse and physical assault experienced by staff.
- However, **continuous monitoring and improvements to each of the areas** covered in this research will no doubt lead to the increased perception among frontline staff groups that they are being effectively supported by their employers in the workplace.

Concluding Implications

- While there are **many positives to reflect upon from this research**, more work is still needed to strengthen the NHS pro-security culture.
- A key aim will be to **increase awareness of the full range of support initiatives** provided by the NHS Security Management Service.

- Those who have attended CRT are generally more aware of NHS security polices and procedures and more positive towards the effectiveness of the security initiatives so **widening access to CRT** should have a positive impact on the NHS security culture overall.

- Among frontline staff there are certain groups that are more at risk. The security needs and priorities of these at risk groups are quite specific so **targeted support** would be clearly beneficial. An example of this is CCTV, which is significantly more likely to make A&E nurses feel safe in their place of work compared to the overall average.

- The NHS Security Management Service should **continue to work with local Trusts** to ensure the environment where staff interact with patients/the public is 'pro-security', as findings indicate that this has an impact on workplace security.

- The NHS Security Management Service needs to **challenge the significant minority** of staff who accept workplace abuse as part of their job and/or are apathetic towards the reporting process.

- With fewer than half of frontline staff agreeing that reporting an incident of verbal or physical abuse leads to a satisfactory outcome, more needs to be done to **convince staff that reporting is worthwhile and leads to satisfactory outcomes**.

- Part of this can be achieved through **better workplace communication from managers** and, if appropriate, **stronger penalties for offenders**.

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Introduction

Introduction

This report presents the findings of a survey of frontline NHS staff conducted by the Ipsos MORI Social Research Institute on behalf of the NHS Security Management Service.

1.1 Background

The NHS Security Management Service (NHS SMS) was established on 1 January 2003 and is part of the NHS Business Services Authority (BSA). The BSA's vision is to provide business solutions that deliver excellent service and value for money for the NHS. Its constituent parts provide a wide range of services to support the NHS frontline and directly to the public.

Within this structure, the NHS Security Management Service bears responsibility for the security of NHS staff and property in England. In accordance with this mandate, the NHS Security Management Service works to:

- protect NHS staff from violence and abuse; and
- take appropriate action against those who abuse, or attempt to abuse, NHS staff.

The aim of the NHS Security Management Service is simple: to protect the NHS so that it can better protect the public's health. For more information about the work of the NHS Security Management Service in tackling violence against staff, please refer to the following guidance documents and published data (also available on the organisation's website):

- Tackling Violence Against NHS Staff
- Non-Physical Assault
- Lone-Workers[3]
- Guidance on the prevention and management of violence where withdrawal of treatment is not an option
- Violence Against NHS Staff Figures[4]

In 2004, the NHS Security Management Service commissioned Ipsos MORI to carry out a quantitative survey of NHS frontline staff to gather information about workplace safety in the

[3] There are a range of documents which relate to lone workers, available on the following section of the BSA website: http://www.nhsbsa.nhs.uk/SecurityManagement/2460.aspx
[4] The figures are available under 'statistics' on the SMS general publications page of the BSA website: http://www.nhsbsa.nhs.uk/SecurityManagement/2286.aspx

NHS. The survey was intended to provide a baseline to help the NHS Security Management Service understand staff's experience of violence at work over time.

The following key findings emerged in the survey:

- A high proportion of NHS frontline staff had experienced multiple incidents of abuse
- Most abuse occurred during daytime hours (though relatively speaking, a higher proportion of physical abuse occurred during the night)
- Most respondents felt their organisation provided a safe and secure working environment
- Awareness of NHS initiatives to deal with violence at work was low
- Reports of abuse were increasing, as was satisfaction with the manner in which NHS deals with reports of abuse (compared with an original pilot study undertaken in 2003)

The NHS Security Management Service commissioned a follow-up study, to assess whether this picture has changed over time. They were keen to measure the progress the organisation has made over this 5 year period in establishing a 'pro-security culture', and to identify any priorities for future work.

They also wished to assess the level of staff awareness of the following NHS Security Management Service initiatives and/or support mechanisms:

- Security Awareness Month (SAM)
- Local Security Management Specialist (LSMS)
- 'Secure' newsletter
- Violence/security/lone-worker policies and procedures
- Reporting procedures (e.g. PARS)
- Conflict Resolution Training (CRT)
- Legal Protection Unit (LPU)
- Promoting Safer and Therapeutic Services (PSTS)

The NHS Security Management Service also wished to hear whether or not, as a result of these initiatives, staff now feel more secure in their places of work.

The 2004 questionnaire also covered issues such as handling controlled drugs, protecting personal and NHS property and security in NHS and maternity wards. These issues were not

covered in the current research but the research expanded upon the specific area of violence against NHS staff.

1.2 Objectives

The overall aim of this research was to enhance the organisation's understanding of the ways in which NHS frontline staff experience violence from the public and patients, so that it is better placed to respond to these challenges with effective and efficient preventive measures.

The specific objectives for this research were as follows:

- To provide information about the ways in which NHS frontline staff experience violence from the public and patients
- To identify causes, triggers, and exacerbating factors
- To identify effective responses to violence towards NHS frontline staff from members of the public and patients
- To assess staff awareness of security policies, procedures and initiatives
- To compare the research findings to the baseline survey and identify progress made in establishing a 'pro-security culture'
- To identify priorities for future work

The research captures information about both physical and non-physical aggression, which are defined by the NHS Security Management Service as follows:

Physical violence:

'The intentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort.'[5]

Non-physical violence:

'The use of inappropriate words or behaviour causing distress and/or constituting harassment.'[6]

[5] Directions to NHS bodies on measures to deal with violence against NHS staff issued November 2003 (amended 2006).
[6] Non-Physical Assault Explanatory Notes issued November 2004.

The quantitative questionnaire, designed by Ipsos MORI in collaboration with the NHS Security Management Service, covers the following:

Nature, frequency and consequences of incident(s)

- Rates of violence towards different frontline staff from the public
- Type/form of violence (verbal/physical)
- Frequency of such violence
- Timing of the incidents (during the day/night)
- Perceptions of factors that gave rise to the incident(s)
- Consequences of violence (time off work, respondent's feelings towards their job and ability to carry out their role etc.)

Characteristics of the victim

- Age
- Gender
- Ethnicity
- Role
- Experience
- Training attendance

Characteristics of the organisation

- Type of NHS organisation
- Environmental factors (heating, lighting, seating, CCTV, noise)
- Arrangements to ensure safety and security in the workplace

Reporting

- Knowledge about reporting policies and procedures
- Level of support from the employer
- Satisfaction with reporting outcomes
- Reasons for non-reporting (if applicable)

Lone working

- Level of support from provided by employer (lone worker devices)
- Perception of safety when working alone

NHS Security Management Service work and priorities

- Views on measures that would help prevent abuse, or act as a deterrent
- Views on the effectiveness of existing NHS Security Management Service initiatives/support mechanisms
- Views about future work priorities for the NHS Security Management Service

Please refer to the appendices to view the quantitative questionnaire in full.

1.3 Methodology

Across England, 2,202 telephone interviews were conducted among frontline NHS staff groups by Ipsos MORI telephone operations, using CATI (Computer Aided Telephone Interviewing), with fieldwork taking place between 13 November and 18 December 2009.

It is important to note that this research does not represent the views of all NHS staff. Rather, the survey sought the views of twenty-five specific groups of staff. A mixture of staff groups who have varying degrees of contact with the public were selected, some with everyday face-to-face contact in open access public environments, and some with more restricted contact in less 'open' environments. In addition, among these groups, we screened to only interview those staff who have any contact with the public. Responses among all staff groups have been aggregated to give overall staff sample figures. However, these should not be taken as representative of the views of NHS staff as a whole, rather just those groups surveyed.

The table overleaf outlines the staff groups and the number of interviews completed within each.

Number of Interviews for Each Staff Group	
Doctor – A&E	50
Doctor – GUM	51
Doctor – older adults	51
Doctor – psychiatrist	49
Doctor – obstetrics/gynaecology	50
Doctor – other	100
Midwives	100
Hospital/ Inpatient nurse	200
Practice nurses	100
Community nurse	100
Community psychiatric nurses	100
Practice managers	100
District nurses	100
Administrative staff	100
Reception/ Ward clerk	100
Health visitor	100
Pharmacist	100
Complaints/ PALS staff	100
Manager / Senior manager	101
A&E nurse	100
Porter	50
Security staff	50
Allied health professionals	50
Dentists	100
Opticians	100
Total	**2,202**

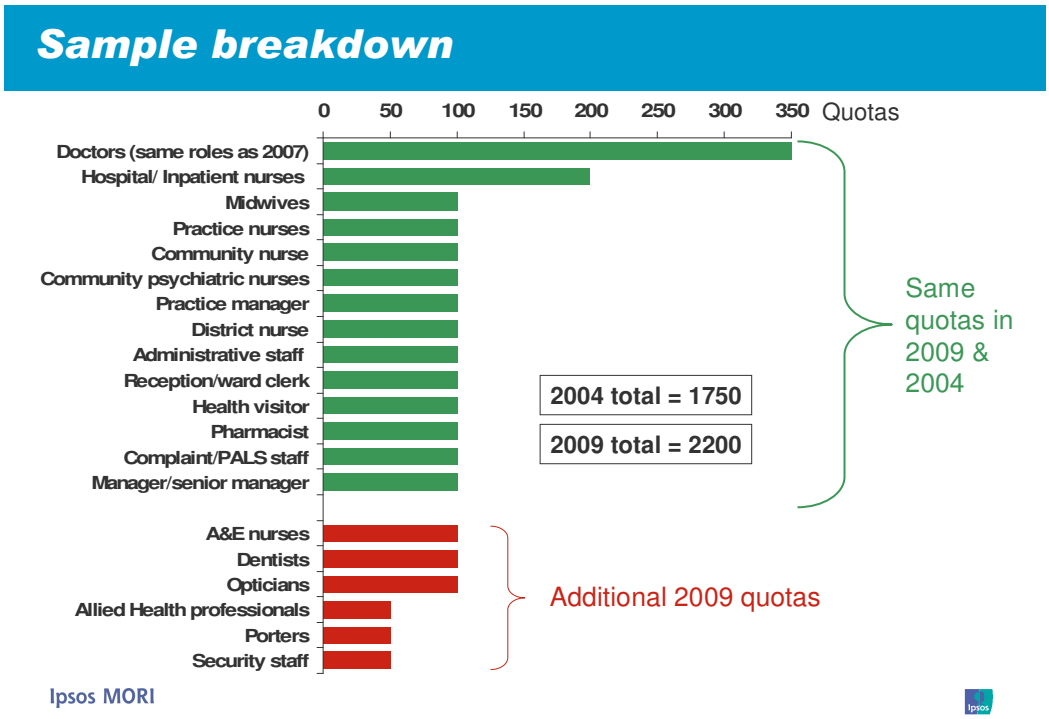
Source: Ipsos MORI

For further technical details, please refer to the marked-up questionnaire in the appendices.

1.4 Sampling

The sample structure for the 2009 telephone survey remained consistent with that used in 2004, but with additional quotas set for Technicians, A&E nurses, Porters, Security staff, Opticians, Dentists and Allied Health Professionals. Details of these additional staff groups, and the overall breakdown of the groups included in this research, can be found in Figure 1.

Figure 1



For each staff group, a minimum of 50, 100 or 200 interviews were conducted (dependent on the respective size of each). This would provide a large enough response size for each (in the case of groups with 100 interviews) to allow robust sub-group analysis at certain questions.

The sampling approach for this research partly required the sourcing of leads and 'free-finding' of staff through NHS switchboards. The following staff groups where sourced by Binley's and Experian using information in the public domain:

- A&E doctor
- GUM registrars
- Psychiatry registrars
- Doctors for older adults
- Obstetrics/gynaecology doctors
- Other doctors and mixed expertise registrars
- Midwives
- Senior A&E and Hospital nurses
- Practice nurses, district and Community psychiatric nurses

- Practice managers
- Health visitors
- Pharmacists
- Complaints/PALS staff
- Allied Health professionals

Additionally, the following staff groups were sourced through a 'free find' approach:

- Technicians
- Administrative staff/Receptionists
- Junior A&E and hospital nurses
- Porters
- Security staff
- Other junior staff

Ipsos MORI interviewers utilised the leads available to achieve the required quotas. Where named contacts from the sourced lists were unavailable, it was requested that alternative participants be invited to take part in the survey (subject to compliance with screening). This approach was found to work effectively in the 2004 research, and this was again found to be the case in the 2009 research.

In terms of the sample profile:

- Majority of respondents are female (72%)
- Largest age group is 45-54 (33%), followed by 35-44 (27%)
- Over four in five work full time (82%)
- Most work in Primary Care (54%), followed by Acute (31%)
- More respondents have less than 2 years' experience in their current role in the 2009 sample compared to 2004 (30% vs. 20%)[7]

[7] Staff who had been in their role for less than one year were not included in the 2004 research. This approach was revised for the 2009 research, and staff with less than a one year's experience are included in this set of results.

- However, over three in four staff in the 2009 sample have over 5 years' experience in their profession (78%)

For further details of respondent demographics, please refer to the final section of the marked-up questionnaire in the appendices.

1.5 Weighting

Throughout this report we have referred to the unweighted 2009 results - both in terms of the topline and sub-group analysis. However, where the opportunity for benchmarking exists, we have compared an additional weighted set of 2009 figures to the 2004 results. The '2009 weighted benchmark' reflects the results for only those staff groups that were originally included in the 2004 research, and is weighted to reflect the number of respondents in each of the original staff groups. The purpose of comparing the weighted benchmark figure for 2009 to the 2004 results, rather than the unweighted figure, is to allow us to benchmark the original groups and remove the possibility that the new staff groups will have an effect on the trend figures. This is why there are three sets of figures shown for the benchmark questions.

It should be noted that the results have **not** been weighted to reflect the wider NHS workforce. This is because this survey has been designed to investigate the views of staff in frontline positions who have direct contact with patients (including frontline managers) rather than the entire NHS workforce. In addition, weighting the NHS workforce carries a number of risks: due to the lack of accurate population data for certain staff groups, weighting to available data is likely to introduce additional biases.

1.6 Interpretation of the Data

It should be remembered that this survey is based on a sample, not the entire population of NHS frontline staff. In consequence, all results are subject to sampling tolerances, which means that not all differences are statistically significant. That said, the sub-group differences that are mentioned in this report are all statistically significant at the 95% confidence level.

An overall sample of 2,202 respondents carries a margin of error of around plus or minus two per cent. Results for different subgroups will need to be further apart for the difference to be statistically significant, depending on the size of the sample and the finding itself – see the section on statistical reliability appended to this report for further details.

Where percentages do not sum to 100, this is due to computer rounding, the exclusion of "don't know" categories, or multiple answers. Throughout the volume, an asterisk (*) denotes any value less than half a percent.

1.7 Acknowledgements

Ipsos MORI would like to thank Clare Fletcher and Martin Wiles at the NHS Security Management Service for their help and assistance in the development of this project. We would also like the thank Claire Gevaux at the Central Office of Information who assisted with the management and delivery of the project.

Most of all, thanks must go to all members of NHS staff who gave up their time to take part in the research programme.

A 'Pro-Security' Culture

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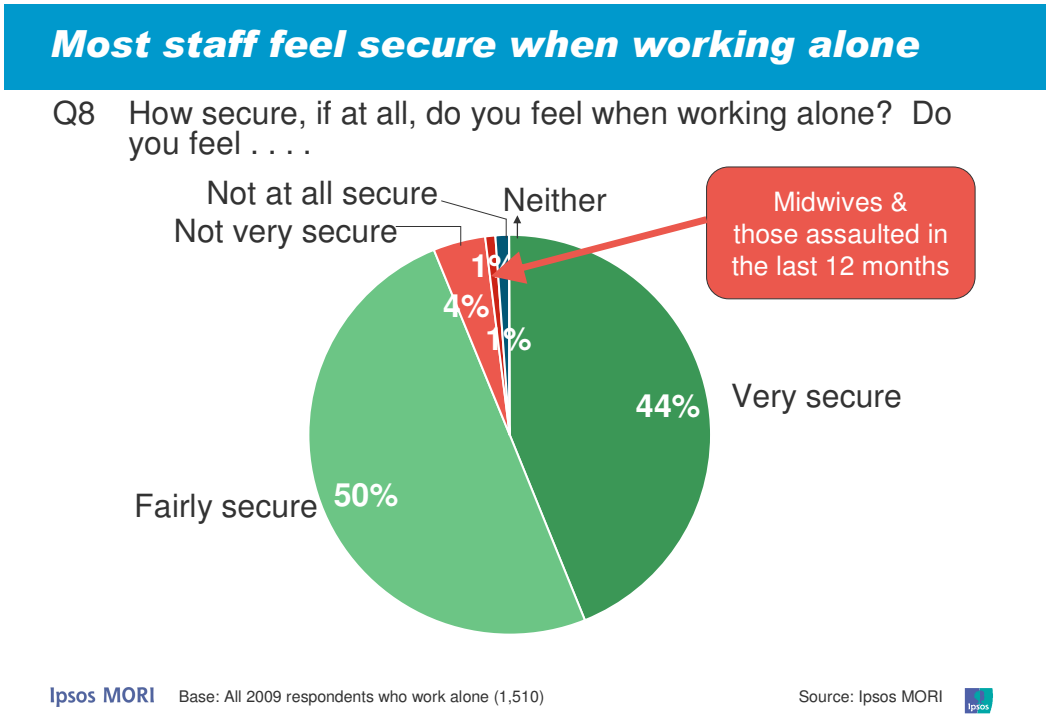
To measure the extent to which a 'pro security' culture exists in the NHS we asked frontline staff how secure they feel when performing their job responsibilities. This included how secure staff feel when they work alone and whether their workplace provides a safe and secure working environment. We also asked when staff last attended Conflict Resolution Training (CRT) – key training for NHS staff on how to deal with incidents in the workplace.

2.1 Working Alone

Over nine in ten (94%) staff – the vast majority – say they **feel secure when they are working alone**. This includes over two in four (44%) who say they feel very secure. Only a small proportion of staff (5%) say they do not feel secure.

Figure 2



The vast majority of staff within each of the staff groups feel secure when they are working alone, but **midwives** (12%), **security staff** (10%) and **A&E nurses** (9%) are more likely than the average (5%) to feel less secure.

Those who have been the victims of **physical assault** (15%) in the last twelve months are more likely to feel less secure when working alone compared to both the average (5%) and those who have been **verbally abused** (8%).

There are no significant differences in the sense of security among those working in different types of Trust.

2.2 Safety in the Workplace

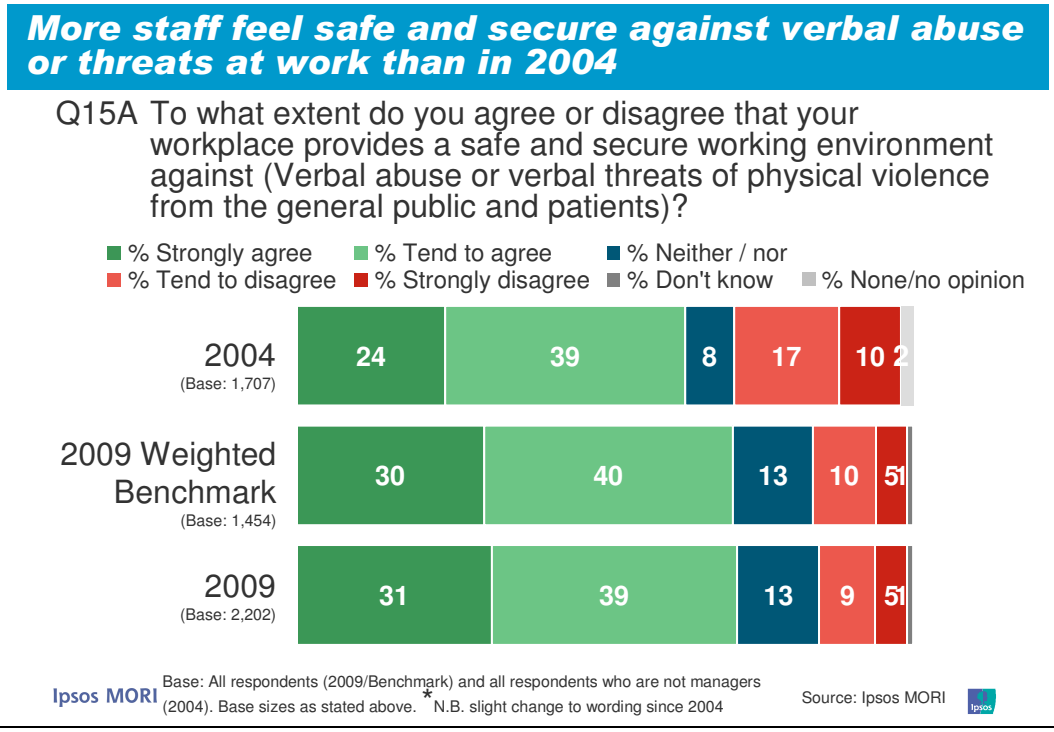
More staff agree that the workplace provides safety against verbal abuse or verbal threats of physical violence compared to the benchmark survey

Seven in ten (70%) staff are in agreement that their workplace provides a safe and secure working environment against verbal abuse or verbal threats of physical violence from the general public and patients. This includes three in ten (31%) who are in strong agreement.

When considering the findings by the 2009 weighted benchmarks (i.e. only those staff groups included in the 2004 research), there is no difference in the proportion agreeing that their workplace provides a safe and secure working environment compared to the overall 2009 results by all staff groups (both 70%).

Comparing the 2009 weighted benchmark results to the 2004 results, there is a seven percentage point increase in agreement that the workplace provides a safe and secure working environment against verbal abuse and verbal threats of physical violence (70% and 63% respectively). This is a significant increase in agreement and indicates staff feel the NHS is doing more to help ensure their safety while at work.

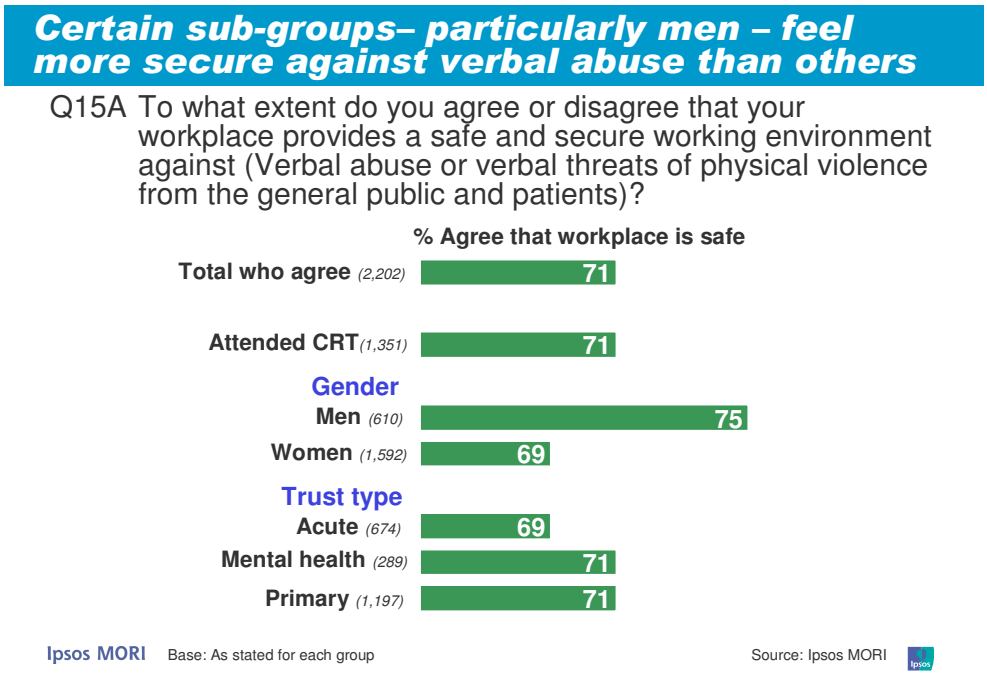
Figure 3

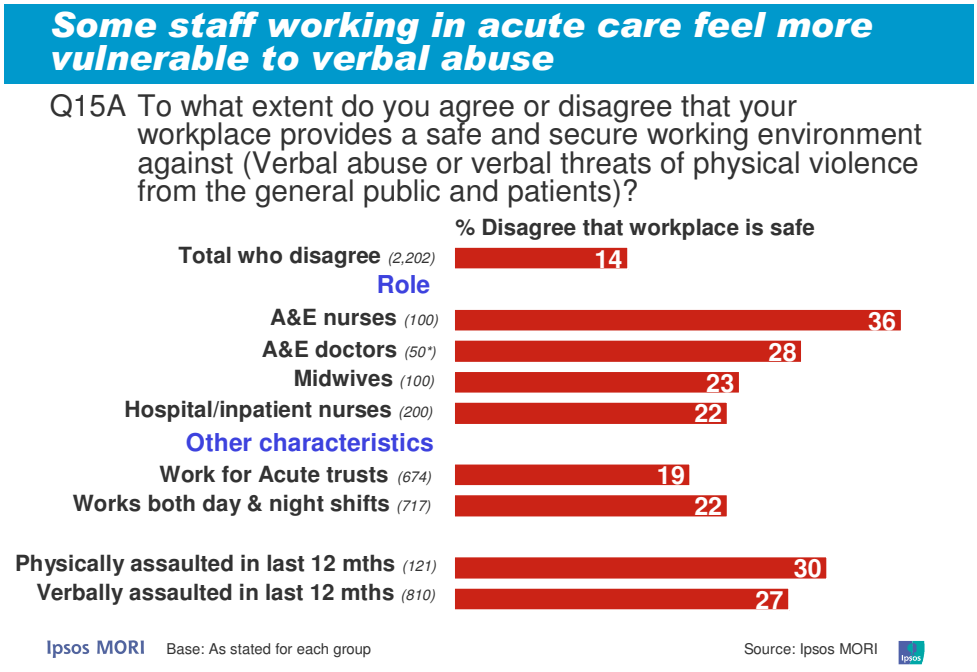


Those who have **attended CRT** in the last year are more likely than **average** to agree that their workplace provides a safe and secure working environment against verbal abuse (75% and 71% respectively).

Men (75%) are more likely than **women** (69%) to agree that their workplace provides a safe and secure working environment against verbal abuse. Other sub-group differences of note are demonstrated in Figures 4 (for agreement) and 5 (for disagreement).

Figures 4 and 5





More staff agree that the workplace provides safety against physical violence compared to the benchmark survey

Three in four (74%) staff agree that their workplace provides a safe and secure working environment against physical violence from the general public and patients. This includes over one in three (35%) who strongly agree with the statement.

Looking at the 2009 weighted benchmarks (i.e. only those staff groups included in the 2004 research), the results are similar for combined agreement that their workplace provides a safe and secure working environment against physical violence (75%).

Encouragingly, when the 2009 weighted benchmark is compared to the 2004 results, there is an eight percentage point increase in agreement (75% versus 67%). As with verbal abuse and verbal threats of physical violence, the results show that significantly more NHS staff feel their workplace provides a safe and secure working environment against physical violence when compared to the findings of the 2004 survey.

Figure 6

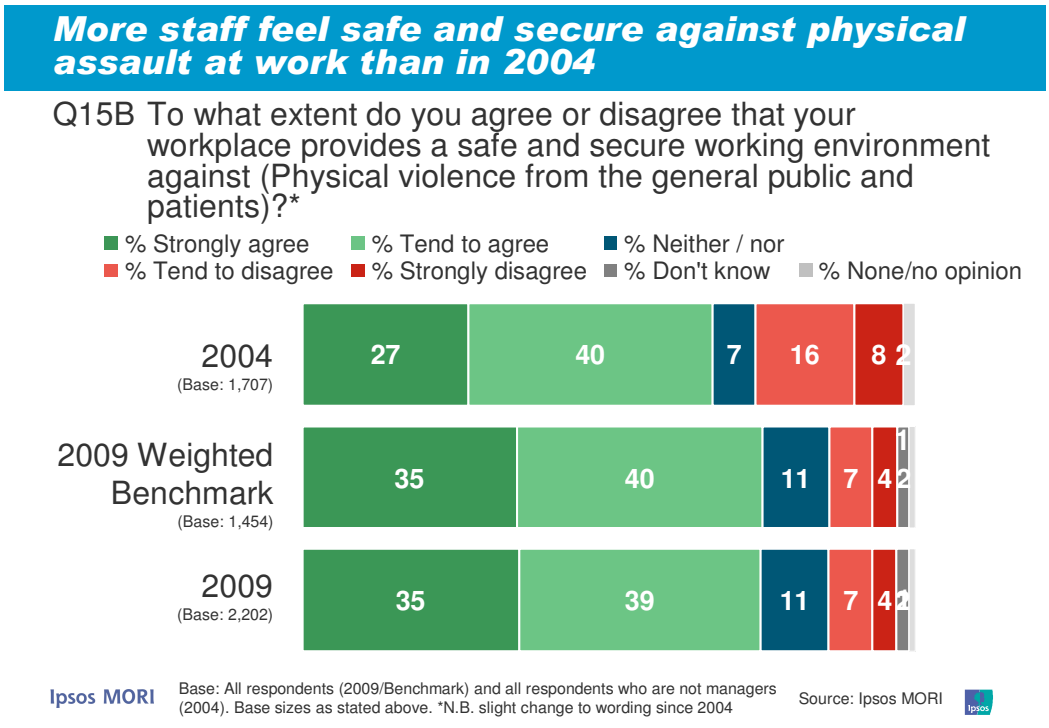
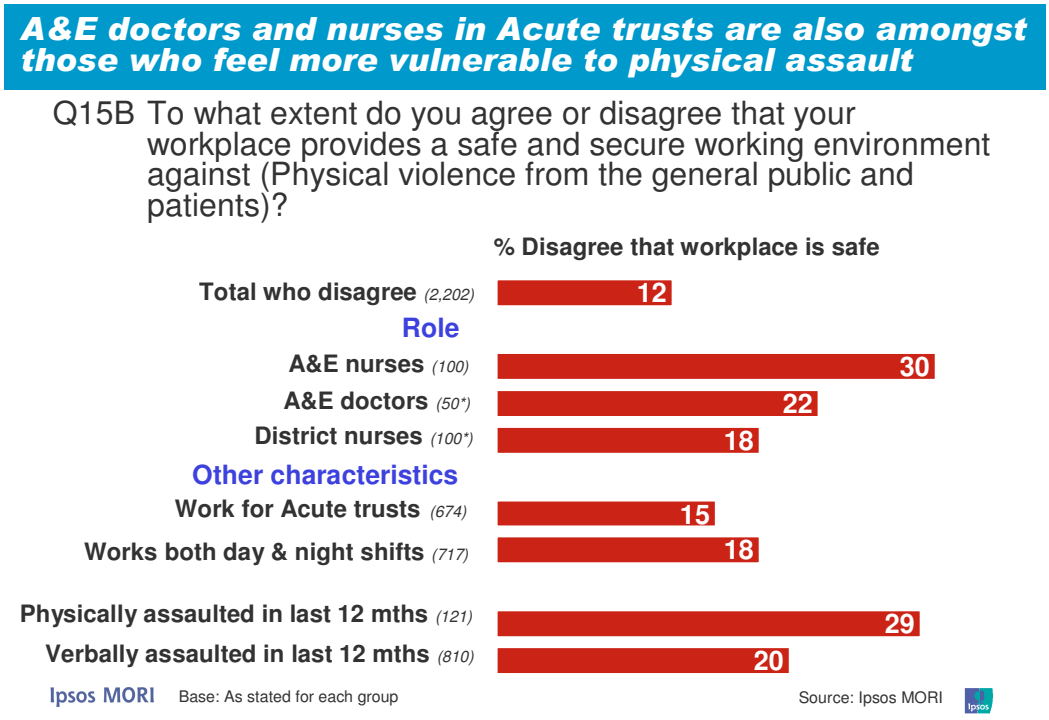


Figure 7



A&E nurses (30%), **A&E doctors** (22%), **district nurses** (18%) and **inpatient nurses** (16%) are all more likely than average (12%) to disagree that their workplace provides a safe and secure working environment against physical violence from the general public and patients.

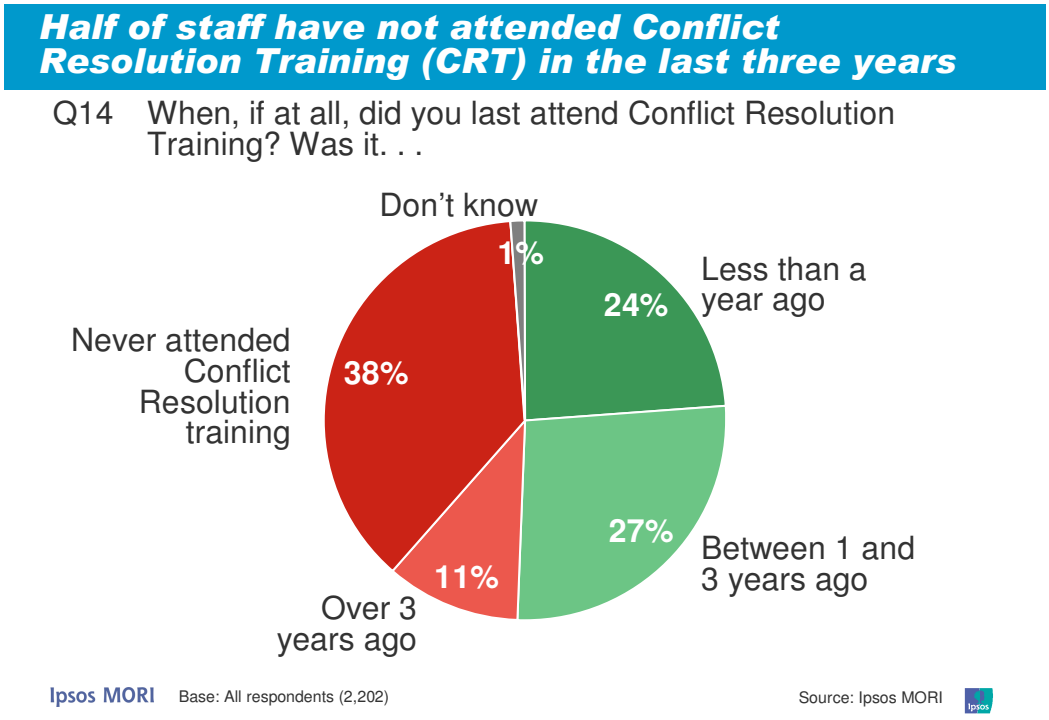
Similarly, staff working in **acute care** (15%) are more likely than those working in primary **care** (11%) and **mental health and learning disability organisations** (8%) and the average (12%) to disagree that their working environment makes them feel safe from physical violence from the general public and patients.

2.3 Attending Conflict Resolution Training

Over half of staff have attended CRT in the last three years

Conflict Resolution Training (CRT) is a key training initiative which helps prepare NHS staff for potential confrontations and incidents in the workplace. When asked about the last time staff attended CRT, one in four (24%) say they did so in the last year. Just over one in four (27%) attended CRT between one and three years ago. However, with approaching two in five (38%) saying they have never attended CRT, there still appears to be scope to increase staff participation in this initiative.

Figure 8



Those who have been in their role for **less than a year** are significantly less likely to have attended CRT compared to those who have more experience, such as those who have been in their roles from **five to ten years** (42% and 34% respectively).

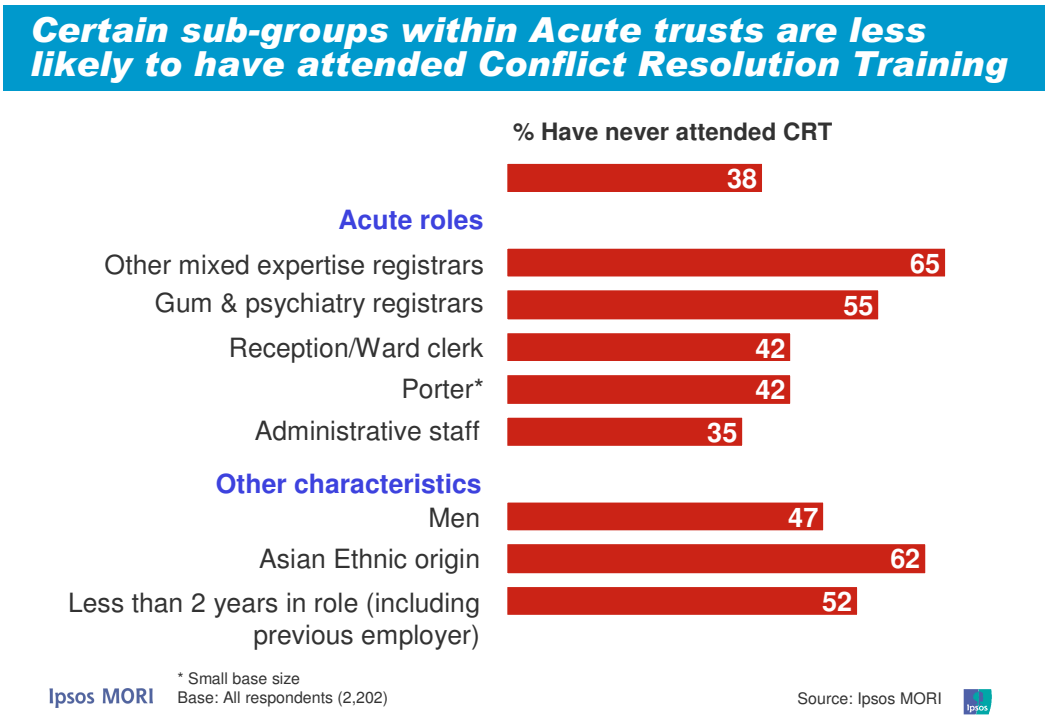
In the acute sector, doctors, including **other mixed expertise registrars** and **GUM & psychiatry registrars** are most likely to have never attended CRT (65% and 55% respectively).

Staff working in **primary care** (39%), and **mental health and learning disability organisations** (40%), are more likely to have **never attended CRT** compared to those working in **acute care** (34%). However, these findings are to be expected as staff from these organisations are likely to have attended alternative training, such as Promoting Safer and Therapeutic Service (PSTS) in the case of mental health and learning disability organisations.

This is also the case with qualified/staff/charge nurses compared to sister/ consultant/ manager nurses (25% and 14% respectively).

Figure 9 also explores some of these sub-group differences.

Figure 9



Staff Awareness of NHS Security Policies and Initiatives

Staff Awareness of NHS Security Policies and Initiatives

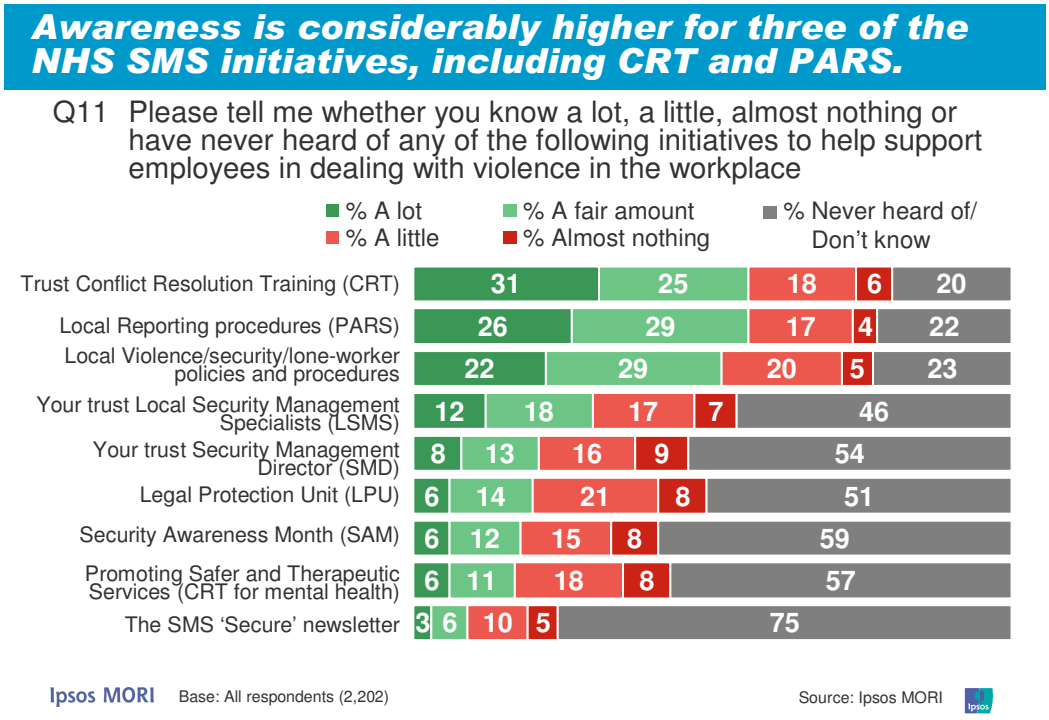
Staff were asked whether they were aware of a number of NHS security polices and procedures which have been implemented by NHS Security Management Service in recent years. Some of these were originally asked about in the 2004 survey, and thus allow a comparison to be made with the 2009 results. We also asked staff about their awareness of any additional mechanisms provided by their employer to support their personal safety and wellbeing while they are at work. To explore this further we asked a question on which initiatives and/or support mechanisms make staff feel more secure in their place of work. This is to gauge the value placed on both NHS Security Management Service initiatives and the support provided by their employers.

3.1 Awareness of NHS Security Management Service Support Initiatives

CRT receives the most recognition from NHS staff, closely followed by PARS and Local violence/security/lone-worker policies and procedures

CRT (56%), Local Reporting Procedures (PARS - 55%) and Local violence/security/lone-worker policies and procedures (51%) are the three NHS Security Management Service initiatives that over half of staff know a lot/a fair amount about. Other NHS Security Management Service initiatives receive significantly less recognition from staff, with three in ten (30%) saying they know a lot/fair amount about their Trust's Local Security Management Specialist (LSMS) and one in five (21%) saying they know a lot/a fair amount about their Trust's Security Management Director (SMD).

Figure 10



Considering CRT, **opticians** (86%), **dentists** (69%), **practice nurses** (47%) and **porters** (44%) are significantly more likely than **average** (25%) to know almost nothing/have never heard of the initiative. Again, this is to be expected among most of these groups, for whom this initiative is not compulsory.

Staff in **acute care** are more likely to say they know a lot/a fair amount about CRT (83%) compared to the **mental health** (73%) and **primary care** (71%) sectors. This is to be expected, as acute staff are the main focus of this initiative.

Staff in mental health and learning disability organisations are significantly more likely to have heard of PARS, local violence/security/lone-worker policies, LSMS, PSTS and the NHS Security Management Service 'Secure' Newsletter than the other respective Trusts. This is to be expected in the case of PSTS as this is the equivalent of CRT for mental health and learning disability organisations.

Further sub-group differences by Trust are demonstrated in Figure 11.

Figure 11

Awareness of NHS SMS initiatives – by Trust type

		Trust type		
Know something (a lot/fair amount/a little) about	**Total** *(2,202)*	**Acute** *(674)*	**Primary care** *(1197)*	**Mental health** *(289)*
	%	%	%	%
Conflict trust resolution training (CRT)	75	83	71	73
Local Reporting procedures (PARS)	71	67	70	**89**
Local Violence/security /lone-worker policies & procedures	73	76	69	**83**
Local Security Mgmt Specialists (LSMS)	47	53	40	**61**
Security Mgmt Director (SMD)	37	46	29	49
Legal Protection Unit (LPU)	41	48	36	47
Security Awareness Month (SAM)	33	37	29	40
Promoting Safer & Therapeutic Services (CRT for Mental Health)	34	29	31	**58**
The SMS 'Secure' Newsletter	20	19	18	**30**

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3.2 Awareness of CRT

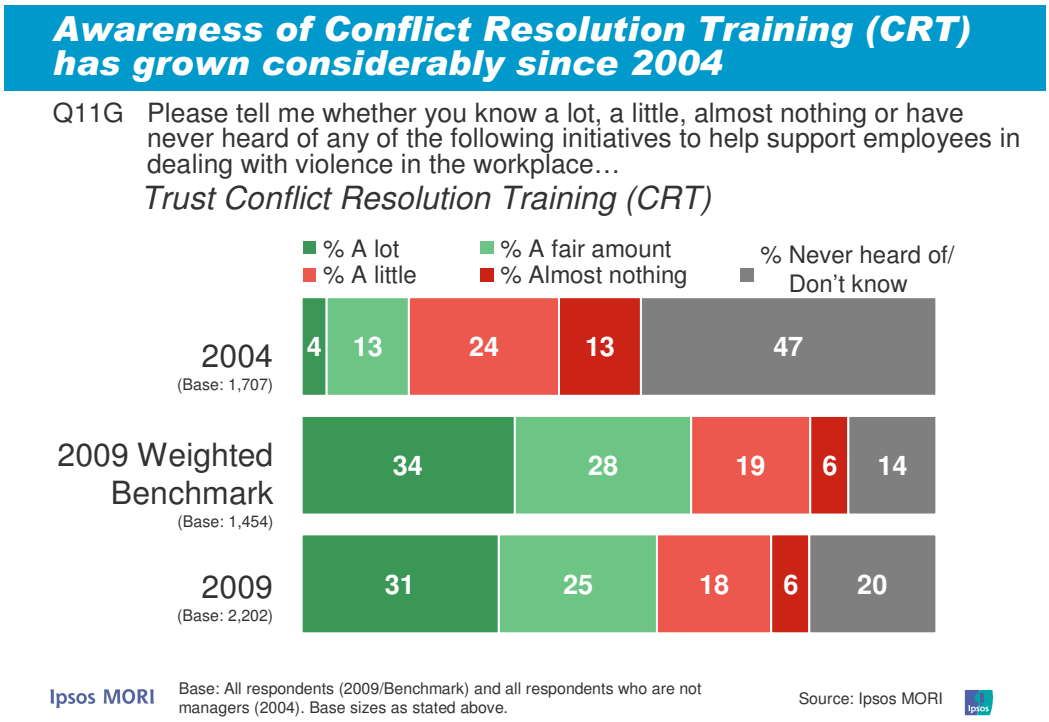
Recognition of CRT has increased significantly since the benchmark survey

To determine the progress NHS Security Management Service has made in promoting its security initiatives throughout the NHS workforce, we measured the changes in staff awareness towards certain initiatives that were originally measured in the 2004 survey.

Fifty-six per cent of staff say they know a lot/a fair amount about CRT in the 2009 survey. When looking at these findings by the 2004 staff groups (2009 weighted benchmark), over six in ten (62%) say they know a lot/a fair amount about CRT – a difference of six percentage points.

Positively, awareness of CRT has clearly grown now that it has had time to 'bed in' to the NHS security culture. In 2004 only seventeen per cent said they knew a lot/a fair amount about the initiative. Asked of the same staff groups in 2009, the combined figure for a lot/a fair amount is sixty-two percent (an increase of 45 percentage points).

Figure 12



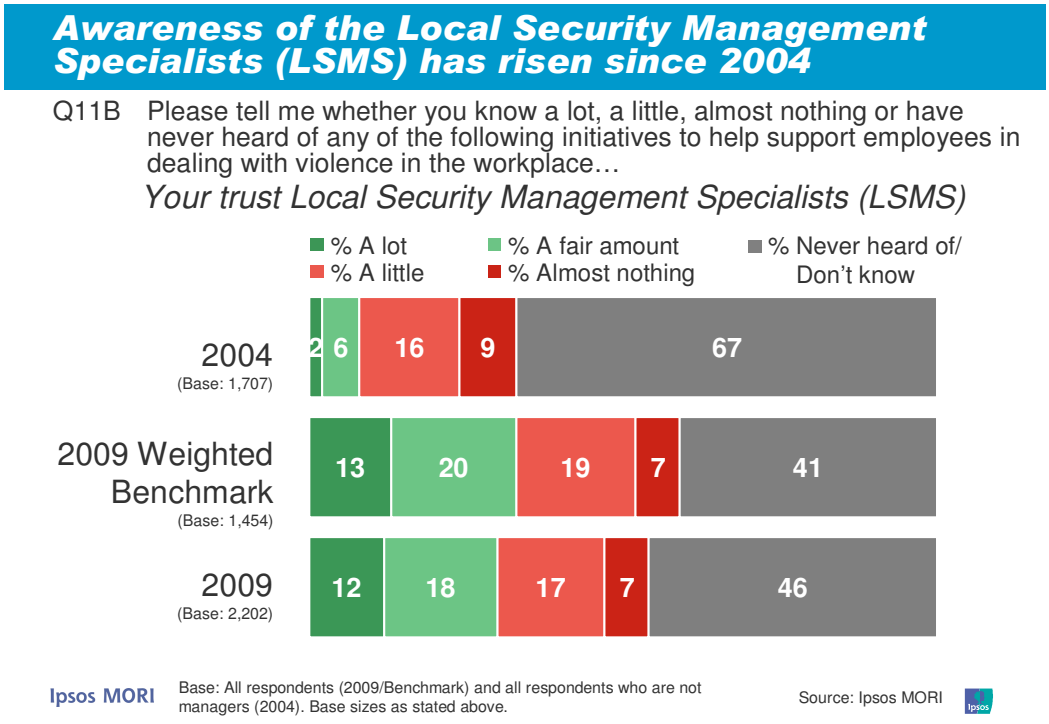
3.3 Awareness of LSMS

Recognition of LSMS has also grown since the benchmark survey, but approaching half of staff have still never heard of the initiative

Awareness of the role of LSMS is also benchmarked in the 2009 survey. Three in ten (30%) say they know a lot/a fair amount about these security specialists, rising to one in three (33%) when considering the findings by the 2004 staff groups (the 2009 weighted benchmark).

Awareness of LSMS has risen since 2004, but perhaps not to the extent that NHS Security Management Service would have hoped for. In 2004 only eight per cent of staff said they knew a lot/a fair amount about the role of LSMS. With one in three (33%) saying they know a lot/a fair amount about the role of LSMS in 2009, there has been a twenty-five percentage point increase in awareness. However, the challenge will be in reducing the proportion of staff who say they have never heard of LSMS (41%).

Figure 13



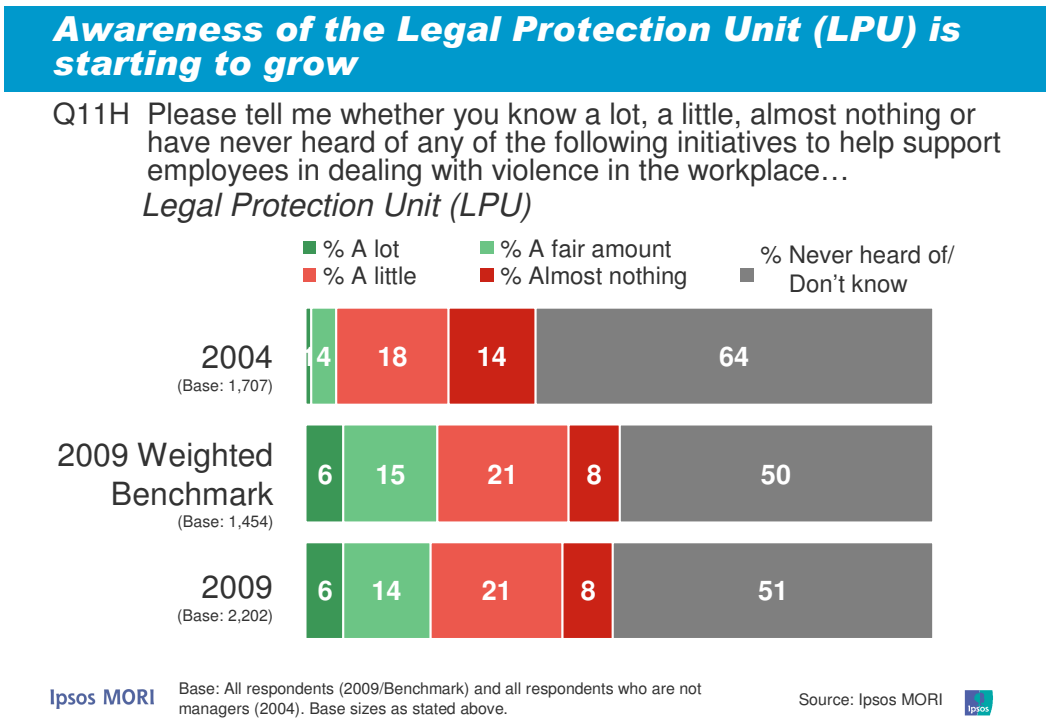
3.4 Awareness of the LPU

Recognition of the LPU has increased in moderate terms, but the majority of staff are not aware of this initiative

One in five (20%) say they know a lot/a fair amount about the Legal Protection Unit (LPU), whilst half of staff say they have never heard of it (51%). When considering the results by the 2004 staff groups (the 2009 weighted benchmark) the results are very similar, with one in five (21%) staff saying they know a lot/a fair amount about the LPU.

As with LSMS, awareness of the LPU has increased since 2004. Only five per cent of staff said they knew a lot/a fair amount about the LPU in 2004, with approaching two in three (64%) staff saying they had never heard of it. Among the same staff groups, the number who say they know a lot/a fair amount about the LPU has risen to twenty one percentage points in 2009.

Figure 14

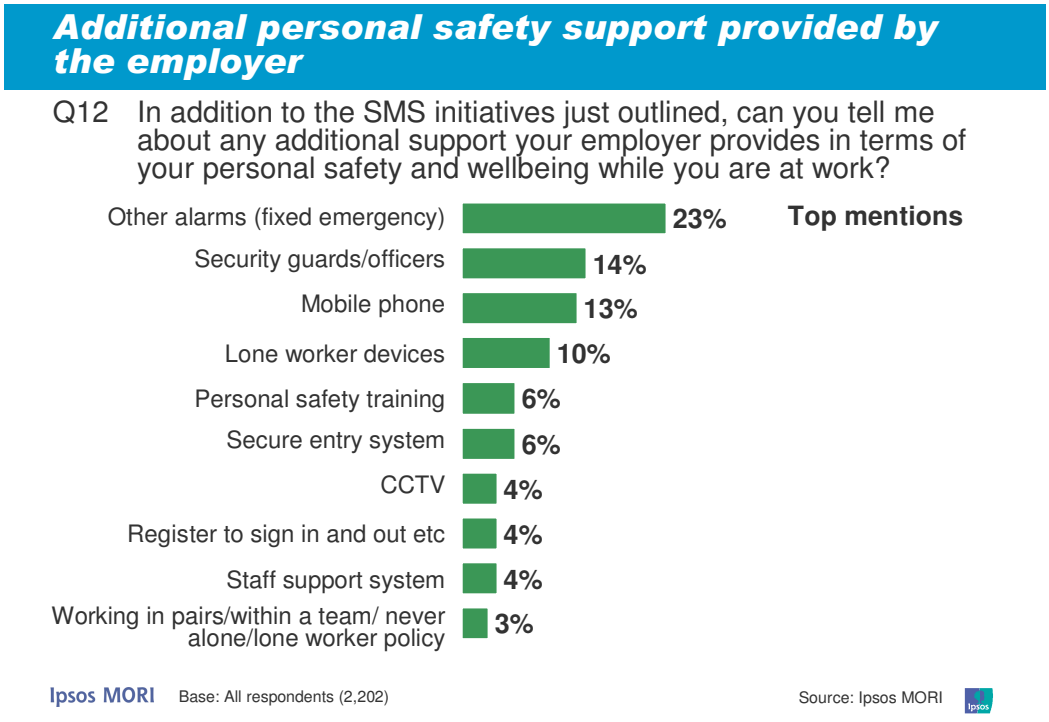


3.5 Additional Personal Safety Support

Fixed emergency alarms, security guards and mobile phones are the most cited additional support initiatives

Staff were asked about the personal safety support their employers provided to ensure their personal safety and wellbeing in the workplace. This relates to policies and initiatives in addition to those of NHS Security Management Service. The most cited response is 'other fixed emergency alarms', with approaching one in four (23%) staff mentioning this feature. This is followed by security guards/officers (14%), mobile phones (13%) and lone worker devices (10%).

Figure 15



Practice nurses and **practice managers** are significantly more likely than **all other staff** groups to say their workplace provides 'other alarms (fixed emergency)' as additional personal safety support (64% and 53% respectively);

A&E doctors and **nurses** are significantly more likely than **all other staff groups** to say their workplace provides security guards/officers (56% and 42% respectively).

Lone workers are more likely to say their employers provide personal safety devices, such as mobile phones and lone work devices, compared to those **who do not work alone** (18% versus 2% for mobile phones and 11% versus 7% for lone worker devices).

3.6 Sense of Security and Support Initiatives

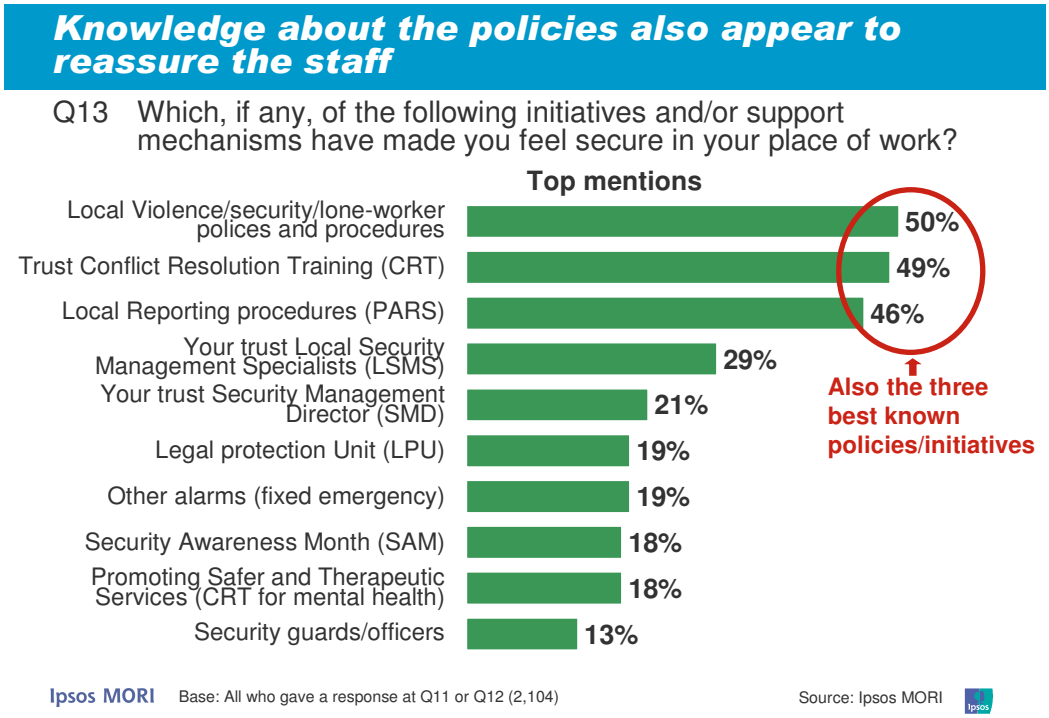
The three most recognised NHS Security Management Service initiatives are also the three most likely to make staff feel secure in their place of work

Considering both the NHS Security Management Service initiatives and those provided by their employers, staff were then asked which initiatives and/or support mechanisms have made them feel secure in their place of work. The majority of the top mentions were from the list of NHS Security Management Service initiatives, with half of respondents mentioning 'local violence/security/lone worker policies and procedures' and CRT (50% and 49% respectively). PARS was also mentioned by approaching half of staff (46%).

Security guards/officers received the most mentions from the additional support provided to staff by their employers (13%). Personal safety devices seem to have limited impact on employees' sense of security, as mobile phones and lone worker devices are mentioned by just over and just under one in ten (12% and 8% respectively).

CCTV – something many employers introduce to increase people's sense of security – is only mentioned by four per cent of staff.

Figure 16



Complaints/PALS staff (76%), **security staff** (71%), **community psychiatric nurses** (71%) **and community nurses** (70%) are among a number of staff groups who are more likely than average to say Local violence/security/lone worker policies and procedures have made them feel secure in their place of work.

Those staff who have **attended CRT in the last year** (77%) are more likely than those who attended it between **one and three years ago** (67%), and those who **attended it over three years ago** (47%) to say that it has made them feel secure in the workplace.

A&E nurses (14%) and **practice nurses** (9%) are significantly more likely than the **average** (4%) to say that CCTV has made them feel more secure at work.

Security staff (48%), **porters** (24%) and **administrative staff** (23%) are significantly more likely than all **other staff groups** (9%), to say the NHS Security Management Service

'Secure' newsletter makes them feel safe in their place of work. However, this should be treated with caution due to the small base size for security staff and porters.

Women are significantly more likely than **men** to say their mobile phone makes them feel safe in the workplace (14% and 6% respectively).

Local Security Management Specialists (LSMS) and Security Management Directors (SMDs) are less likely to make staff in primary care feel secured than staff in either mental health or acute care (as highlighted in Figure 17 below)

For other differences by organisation type, Figure 17 provides a breakdown of the top ten initiatives mentioned overall.

Figure 17

Initiatives that make staff feel secure – by Trust type

		Trust type		
Top 10 initiatives that make staff feel secure	**Total** *(2,202)*	**Acute** *(674)*	**Primary care** *(1197)*	**Mental health** *(289)*
	%	%	%	%
Local Violence/security/lone-worker polices and procedures	50	44	49	**65**
Trust Conflict Resolution Training (CRT)	49	53	48	48
Local Reporting procedures (PARS)	46	47	43	**56**
Your trust Local Security Management Specialists (LSMS)	29	37	21	39
Your trust Security Management Director (SMD)	21	27	15	28
Legal protection Unit (LPU)	19	20	17	**26**
Other alarms (fixed emergency)	19	14	20	**28**
Security Awareness Month (SAM)	18	21	16	21
Promoting Safer and Therapeutic Services (CRT for mental health)	18	14	15	**39**
Security guards/officers	13	**27**	7	6

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How Frontline NHS Staff Experience Violence

How Frontline NHS Staff Experience Violence

To understand the extent to which NHS security policies and initiatives are having an impact on safety and security we asked staff a number of questions about their experiences of verbal and physical abuse. This included questions on the type and frequency of abuse they have experienced, if any, and the effect it has had on them personally. We also asked whether they have also witnessed colleagues being verbally abused or physically assaulted.

4.1 Personal Experience of Verbal Abuse/Threats and Physical Assault

Positively, there has been a decline in the number of staff experiencing verbal abuse and physical assault

One in three (32%) NHS staff say they have been verbally abused or verbally threatened by a patient in the last 12 months. This is followed by approaching one in five (18%) who say they have been verbally abused or verbally threatened by a member of the public (not a patient). One in twenty (5%) staff say they have been physically assaulted by a patient, and one per cent say they have been assaulted by a member of the public (not a patient).

On physical assault experienced in the workplace, the findings from this 2009 NHS Security Management Service research are in line with those of the Care Quality Commission NHS staff survey 2009[8]. The Care Quality Commission staff research shows that eight per cent say they have been physically assaulted by a patient/service user, and one per cent by a member of the public[9].

While it is not possible to benchmark the specific incidents of abuse and violence that staff have experienced with the 2004 survey (due to definitional changes which reflect the changes in the terminology used within the NHS), we can compare the proportions of staff who say they had experienced 'none of these'. Approaching two in three (63%) of all staff taking part in the 2009 research say they have not experienced either verbal or physical abuse in the workplace. The proportion remains the same when considering the 2009 results by the 2004 staff groups (the weighted benchmark) – sixty three per cent. There is a nine

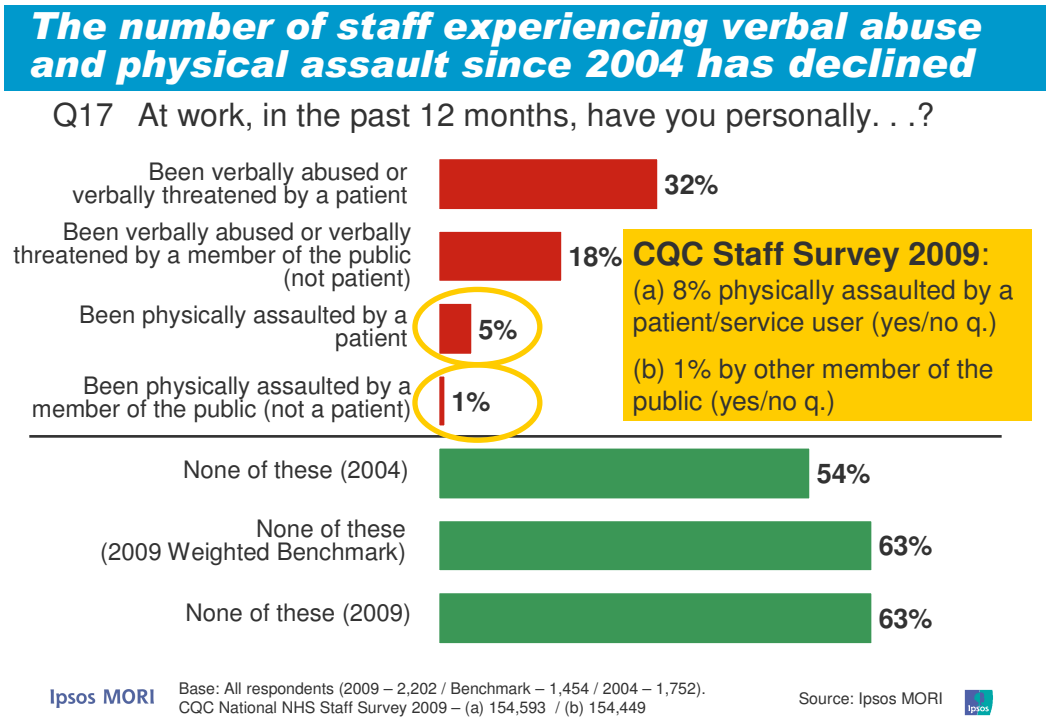
[8] Care Quality Commission NHS staff survey 2009 (base: (Q27a) 154,593 / (Q27c) 154,449 responses)

[9] Comparisons between the NHS Security Management Service research and the Care Quality Commission staff research should be treated as indicative. This is due to the methodological and question format differences between the two surveys.

percentage point increase in the number of staff who have not experienced either verbal or physical abuse since the 2004 survey, when fifty-four per cent said this was the case.

This suggests that there have been improvements in the NHS with regard to workplace safety and security – perhaps reflecting that NHS Security Management Service policies are gradually contributing to a stronger 'pro-security' culture.

Figure 18



We will explore the sub-groups in more detail at section 6.1 to identify the 'at risk' groups.

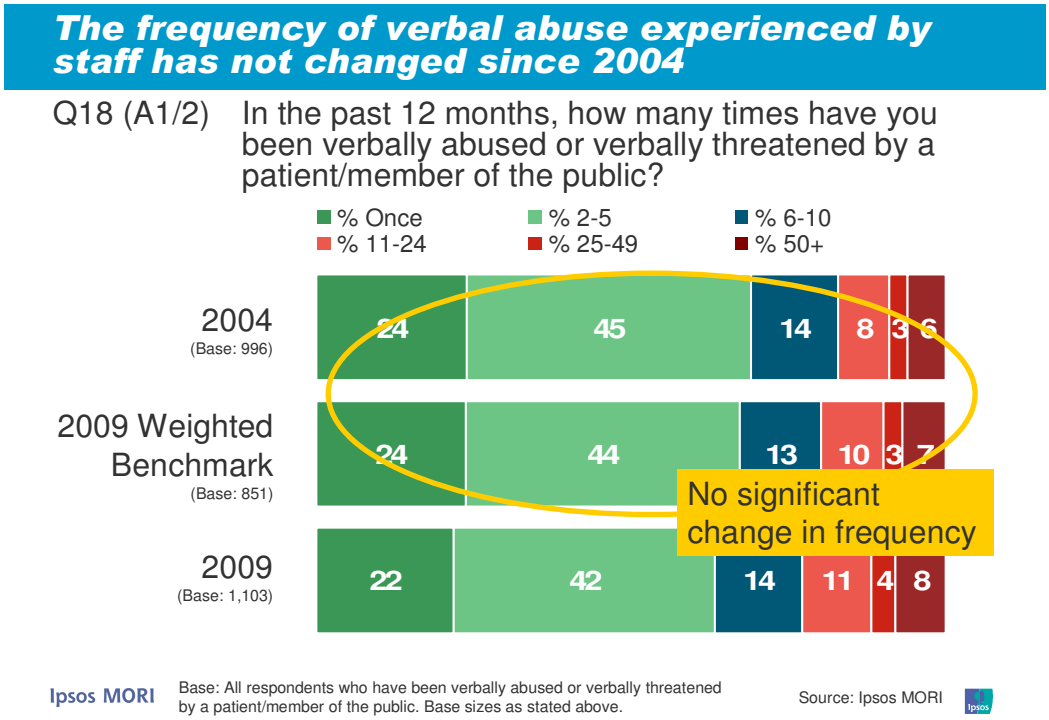
4.2 Frequency of Verbal Abuse/Threats and Physical Assault

The frequency of verbal abuse remains consistent with the benchmark survey

Among just those staff who have experienced abuse, just over one in five (22%) say they have been verbally abused or threatened on one occasion in the last twelve months. Forty two per cent say that they have experienced this type of abuse on two to five occasions.

The results show no significant change from the 2004 results, indicating that while there has not been a significant change in the frequency of verbal abuse among those who have experienced it, it should be borne in mind this is in the context of an overall fall in the number of staff who say they have experienced the abuse.

Figure 19



Staff in **primary care** (23%) are more likely than those in **acute care** (15%) and those working for **mental health and learning disability organisations** (14%) to have been verbally abused once in the last twelve months.

Those staff who have **never attended CRT** (25%) are also more likely than those who have **attended in the last 12 months** (13%) to have experienced verbal abuse on one occasion in the last year.

The **role of staff** rather than **the type of organisation** appears to have more of an impact on the likelihood of staff experiencing verbal abuse. However, the small base sizes of the staff that have experienced abuse mean these findings should be treated with caution,

In terms of multiple incidents of verbal abuse, there are no significant differences between the types of organisation.

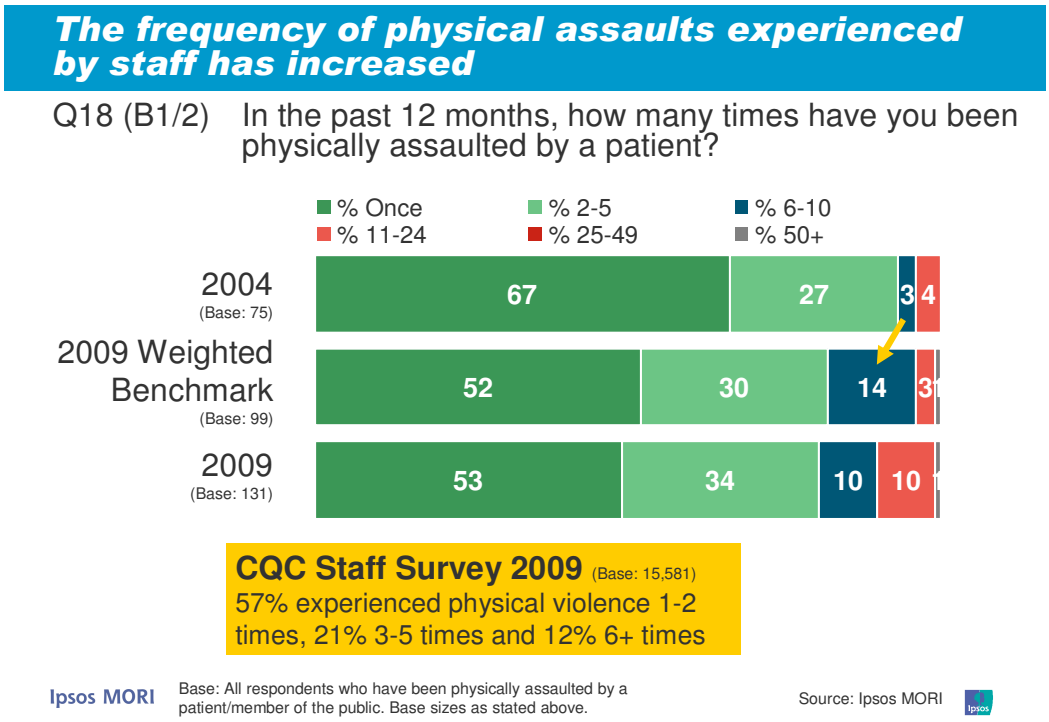
The frequency of physical assaults has increased since the benchmark survey, but this is in the context of an overall decline in the number of staff who have been affected

The findings are somewhat different when considering the frequency of physical abuse experienced by staff. Over half (53%) of staff who have experienced physical abuse say they

have been physically assaulted by a patient or a member of the public on one occasion in the last twelve months, while one in three (34%) say this has occurred on two to five occasions.

When compared to the 2004 results, the findings do suggest there has been an increase in the frequency of physical assault. However, it should be noted that the base size for this question was only 75 respondents in 2004, so this assertion should be treated with caution.

Figure 20



The small base size for the number who have experienced physical abuse means that sub-groups analysis is not possible here.

4.3 Effects of Verbal Abuse/Threats and Physical Assault

The majority of staff say they have not been affected following an incident of verbal abuse, but significantly fewer say this was the case following a physical assault

Over six in ten (62%) staff say they have not been affected following incidents of verbal abuse or verbal threats of physical violence from members of the public or patients. The proportion who say they have not been affected falls to thirty-seven per cent when considering physical assault they have experienced. This is not surprising, considering the seriousness of such incidents and the likely impact they will have on the victim's wellbeing.

Around one in four say they have experienced emotional and/or psychological distress as a result of verbal abuse - roughly the same proportion who report emotional and/or psychological distress following an incident of physical assault (25% and 27% respectively).

Other effects staff are likely to say they have experienced as a result of verbal abuse:

- Felt less safe in the workplace (5%);
- Experienced less job satisfaction (4%).

Other effects staff are likely to say they have experienced as a result of physical assault:

- Suffered a short-term physical injury (17%);
- Have learned more about personal safety through the NHS (7%);
- Feel less safe in the workplace (5%);
- Have taken time off work (5%).

There are also a range of responses given by fewer than four per cent of staff that should not be ignored. While it is the case that some staff appear to be immune and consider incidents of verbal and physical abuse to be 'part of the job', some staff are suffering short and long-term consequences.

Figure 21

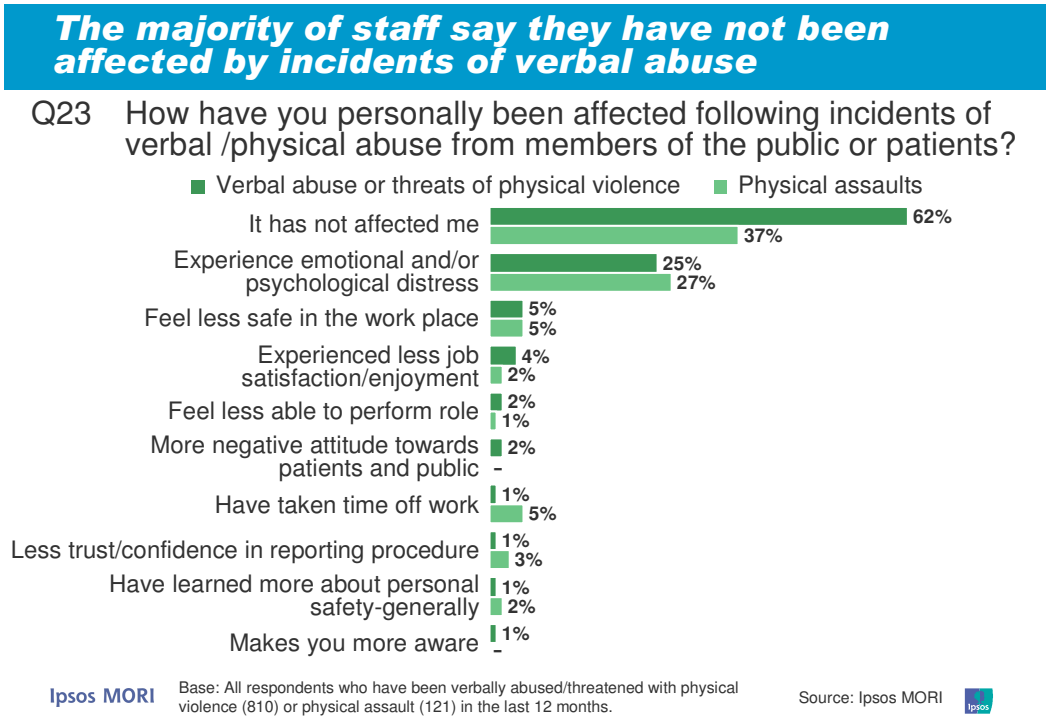
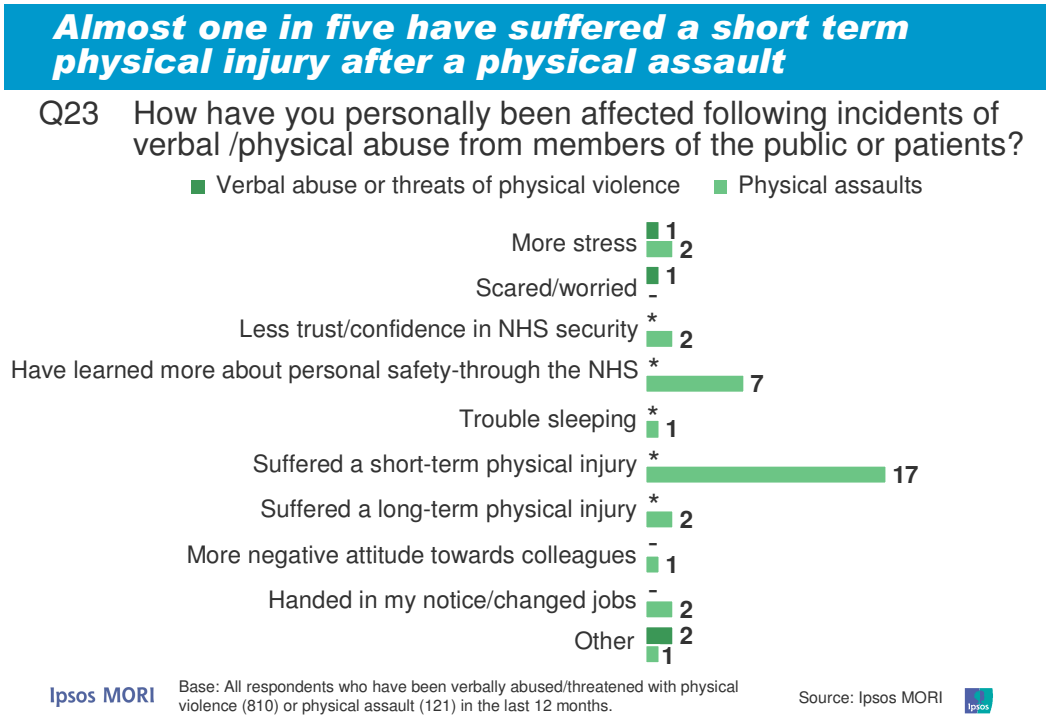


Figure 22



Staff who have been in **their role up to two years** (71%) are more likely to say they have not been affected by verbal abuse compared to those who have been in **their role between two and five years** (55%), **five and ten years** (58%) and **ten years or more** (61%).

Those working for **mental health and learning disability organisations** (74%) are also more likely than those **working in primary care** (59%) and **acute care** (61%) to say they have not been affected by verbal abuse.

Women (27%) are more likely than **men** (19%) to say they have experienced emotional and/or psychological distress following an incident of verbal abuse.

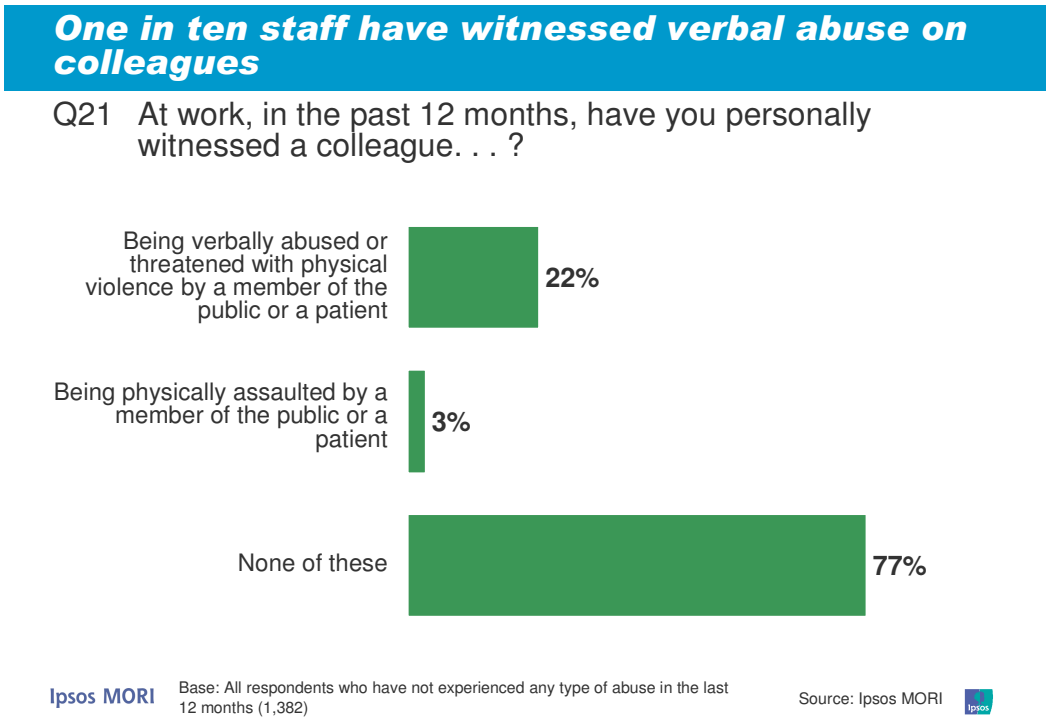
4.4 Witnessing Verbal Abuse/Threats and Physical

The majority of staff have not witnessed a colleague experience a type of abuse

As well as their personal experience of verbal and physical abuse, staff were also asked whether they have witnessed colleagues experience a type of abuse. Around one in five (22%) say they have witnessed a colleague being verbally abused or verbally threatened by a member of the public or a patient in the last twelve months. In terms of a physical assault by a member of the public or a patient, only three per cent say they have witnessed such an incident take place.

Overall, the majority (77%) say they have not witnessed any incidents taking place.

Figure 23



Those **working both day and night shifts** (29%) are more likely to have witnessed a colleague experience verbal abuse compared to those **only working during the day** (20%).

Those who **agree that their workplace provides a safe and secure working environment** against verbal abuse are more likely than those **who disagree with this statement** to not have witnessed any incidents of abuse towards colleagues in the past twelve months (79% and 62% respectively).

The same trend applies to those who **agree**, compared to those who **disagree**, that their workplace provides a safe and secure working environment against physical assault (78% and 66% respectively).

Potential Causes, Triggers and Exacerbating Factors

Potential Causes, Triggers and Exacerbating Factors

Having identified the proportions of NHS staff that have experienced verbal and physical abuse in the workplace - and the frequency with which these incidents have occurred - we then sought to identify the potential causes, triggers and exacerbating factors of the incidents of verbal abuse and physical assault. This included the identification of the groups at most risk, the time at which incidents have occurred, contributory environmental factors and what staff identify to be the main factors that have caused the incidents.

5.1 The Groups at Risk

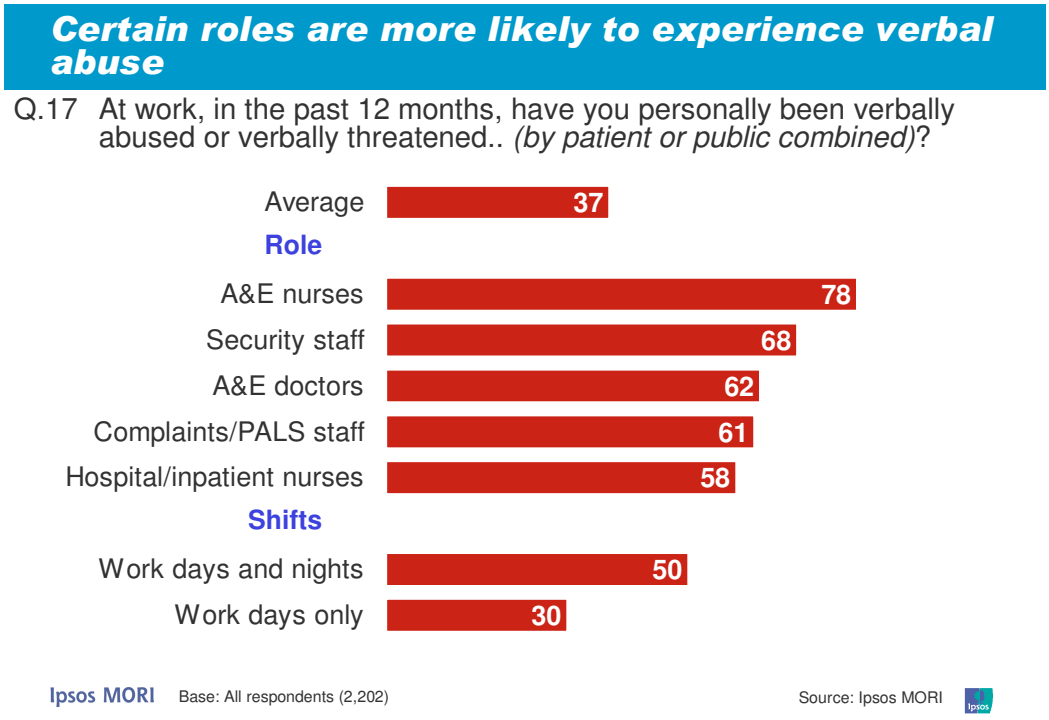
Those working in A&E services, inpatient services and security services appear to be the most a risk from abuse

Revisiting question seventeen (staff experiences of violence) by the sub-groups, we looked at the extent to which the role of staff has an impact on the likelihood that they will experience verbal abuse or threats.

Overall, approaching two in four (37%) staff say they have experienced verbal abuse or verbal threats in the workplace. However, certain staff groups are much more likely to say they have experienced this type of abuse – particularly those in A&E, security, nursing and complaints roles (all significantly more likely than the average).

Time of day also appears to have some impact on whether staff have experienced a type of abuse. Of those staff who work during the day, three in ten (30%) say they have experienced verbal abuse or verbal threats compared to half of staff (50%) who work both day and night. While no staff in this survey say they work just night shifts, the findings do suggest that staff who work outside conventional 9-5 hours are more likely to experience verbal abuse.

Figure 24



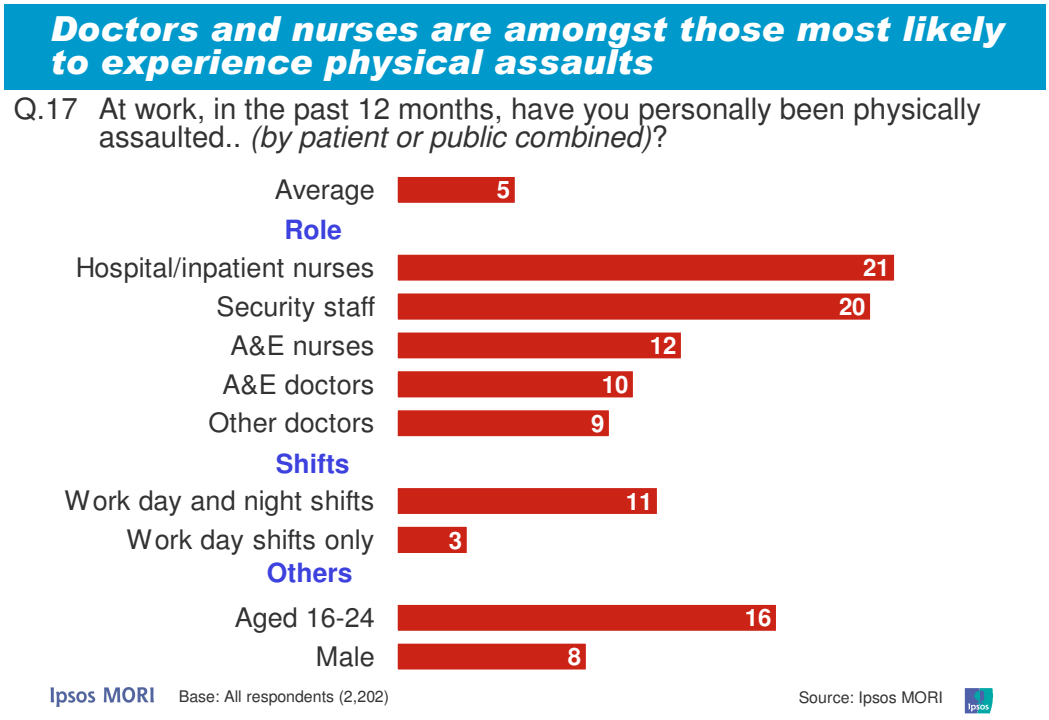
We also considered whether specific staff groups were more likely to experience physical violence than the average.

Overall, one in twenty (5%) staff say they have personally experienced a physical assault in the workplace. As with verbal abuse, this figure is significantly higher among those in **A&E**, **nursing** and **security roles**. **Hospital/inpatient nurses** and **security staff** are two groups that appear to be at particularly high risk (21% and 20% respectively).

As with verbal abuse, the **time of day** when staff work appears to have an effect on how likely they are to experience physical abuse – although the small base size means this assertion should be treated with caution.

Additionally, **age** and **gender** appear to have an impact on which members of staff are more likely to experience abuse. The findings certainly suggest younger staff aged **16-24** (16%) and **men** (8%) are significantly more likely to experience physical abuse than the overall average.

Figure 25



5.2 The Time when Incidents Occur

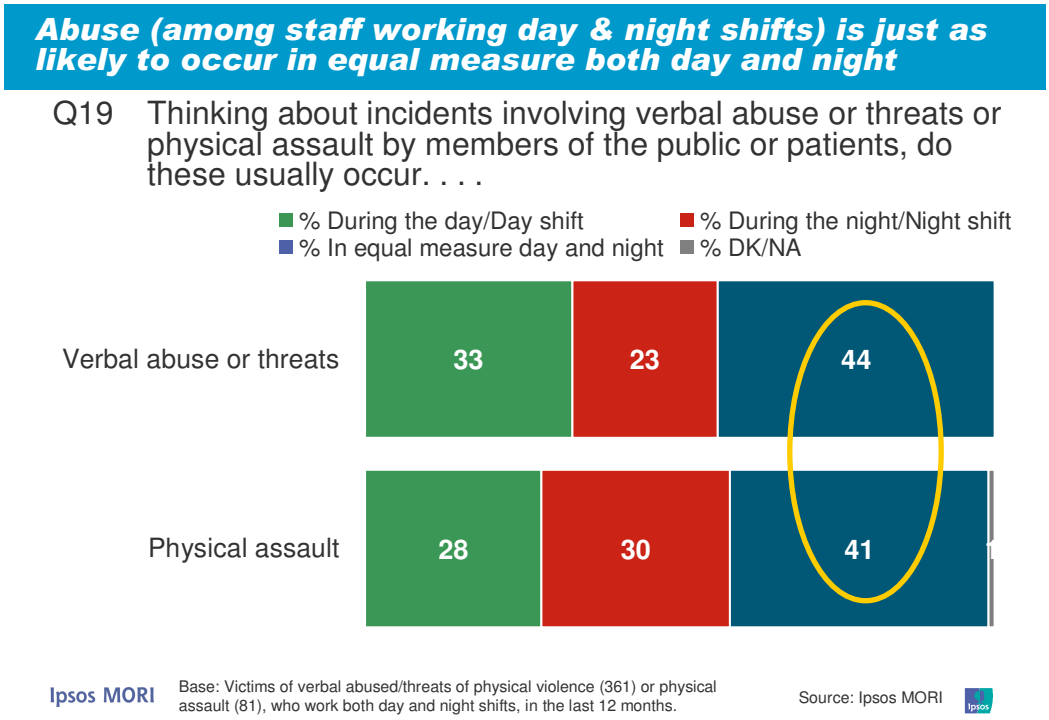
Most staff perceive incidents to occur in equal measure during the day and the night

We have already identified from sub-group analysis that people who work both day and night shifts are more likely than those who work just day shifts to experience verbal abuse or physical assault. To investigate this further, we asked staff who had experienced either verbal abuse or physical assault in the workplace when the incidents are likely to occur.

Although staff appear to be more at risk if they work both day and night shifts, as opposed to just during the day, staff working both shifts say they tend to experience verbal or physical abuse in equal measure both during the day and at night (44% and 41% respectively).

It should be noted that staff who have experienced a physical assault are more likely to say the incident(s) occurred during the night/a night shift compared to those who have experienced verbal abuse (30% and 23% respectively). While no staff in this survey say they work just night shifts, the findings do suggest that staff who work outside conventional 9-5 hours are more likely to experience verbal abuse.

Figure 26



5.3 Environmental Factors

The quality of lighting, the availability of seating and the level of noise are most positively viewed environmental factors

It is possible that environmental factors have an impact on whether or not staff experience abuse or physical assault in the workplace. To determine whether there is a link between these variables, we asked staff to say how good or poor a number of environmental factors are in the place where they interact with patients and the public.

The environmental factors that receive the highest positive combined ratings (very good/fairly good) include:

- The quality of the lighting (83%);
- The availability of seating for patients and the public (77%);
- The level of noise (69%).

In contrast, the environmental factors that receive the lowest positive combined ratings (very good/fairly good) include:

- The provision of refreshments (50%); and

- The provision of smoking areas (19%).

Figures 27 and 28 demonstrate the full range of environmental factors asked of staff, and how they were rated.

Figure 27

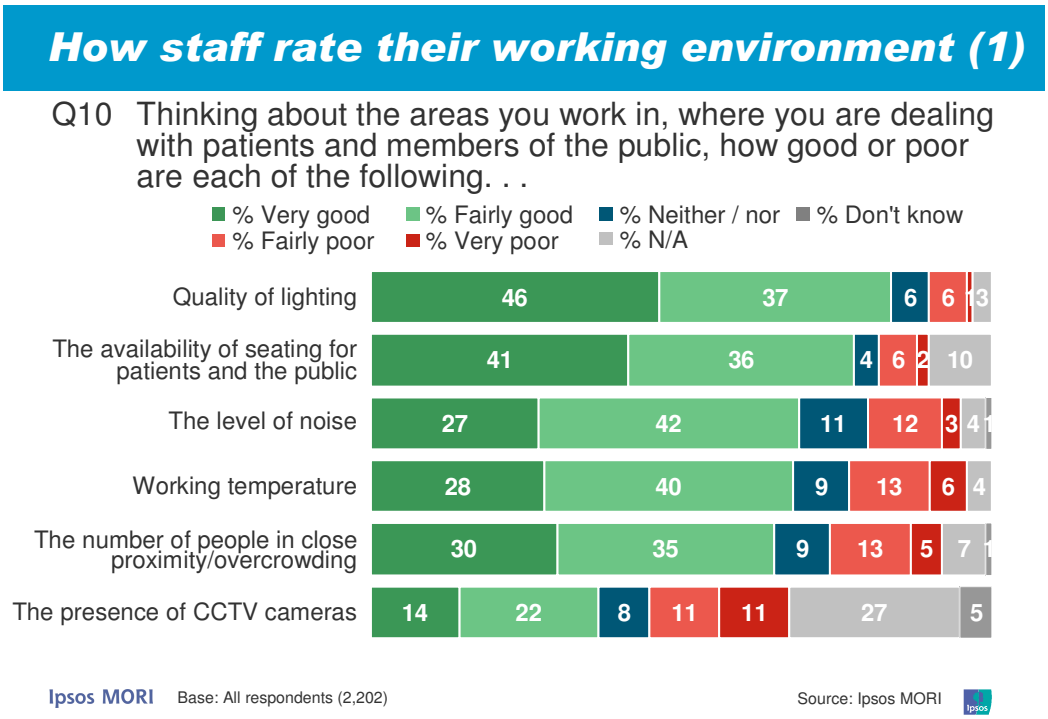
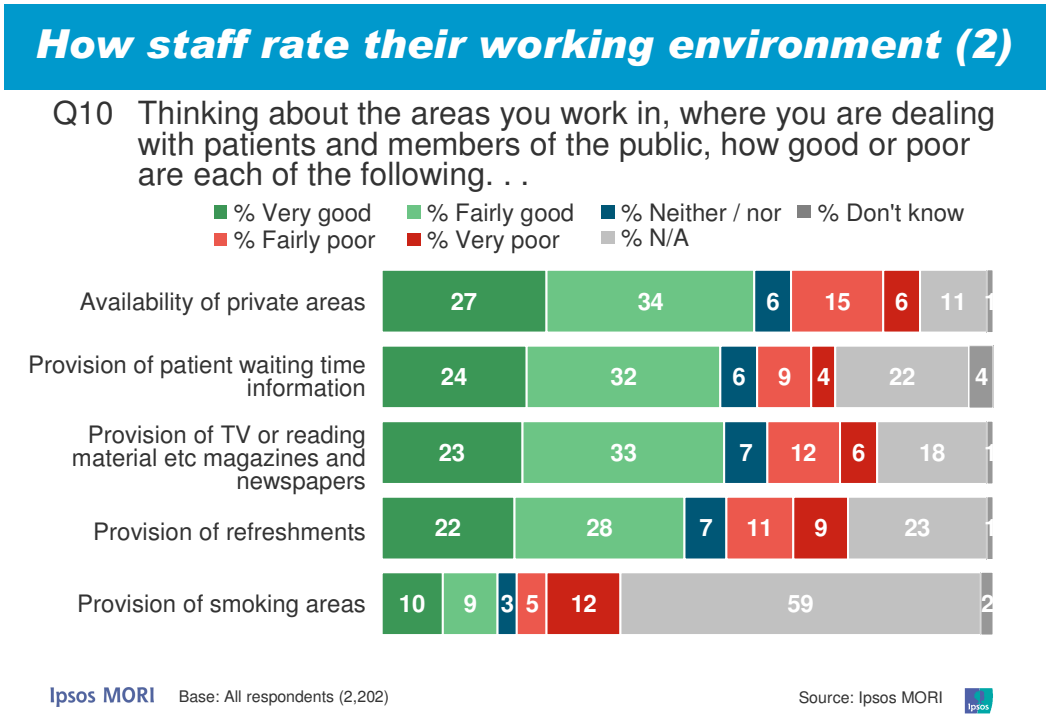


Figure 28



The quality of certain environmental factors can have an impact on the likelihood that staff will experience abuse

It seems that environmental factors do play a role in the likelihood that a staff member will experience either verbal or physical assault. Where staff rate each of the following environmental factors as good, rather than poor, they are significantly more likely **not** to have experienced either verbal or physical abuse:

- Working temperature (66% good versus 50% poor);
- Quality of lighting (64% versus 50%);
- Level of noise (67% versus 46%);
- Number of people in close proximity (67% versus 46%);
- Waiting time information (64% versus 52%);
- TV or reading material (64% versus 48%);
- Private areas (64% versus 51%);
- Availability of seating (63% versus 46%).

Some environmental factors, whether rated good or poor, have less of an impact on the number of staff who say they have experienced verbal abuse or physical assault. The following have a less than significant impact on the number of staff who have **not** experienced workplace abuse, although the findings do still suggest a degree of influence:

- Refreshments (61% good versus 58% poor);
- CCTV (60% versus 55%);
- Smoking areas (61% versus 55%).

While further research would be required to make more substantive conclusions about the role of environment and staff safety, the results do suggest that where environmental factors are good (particularly in terms of the level of noise and the number of people in close proximity) this has a positive impact on staff safety and security in the workplace.

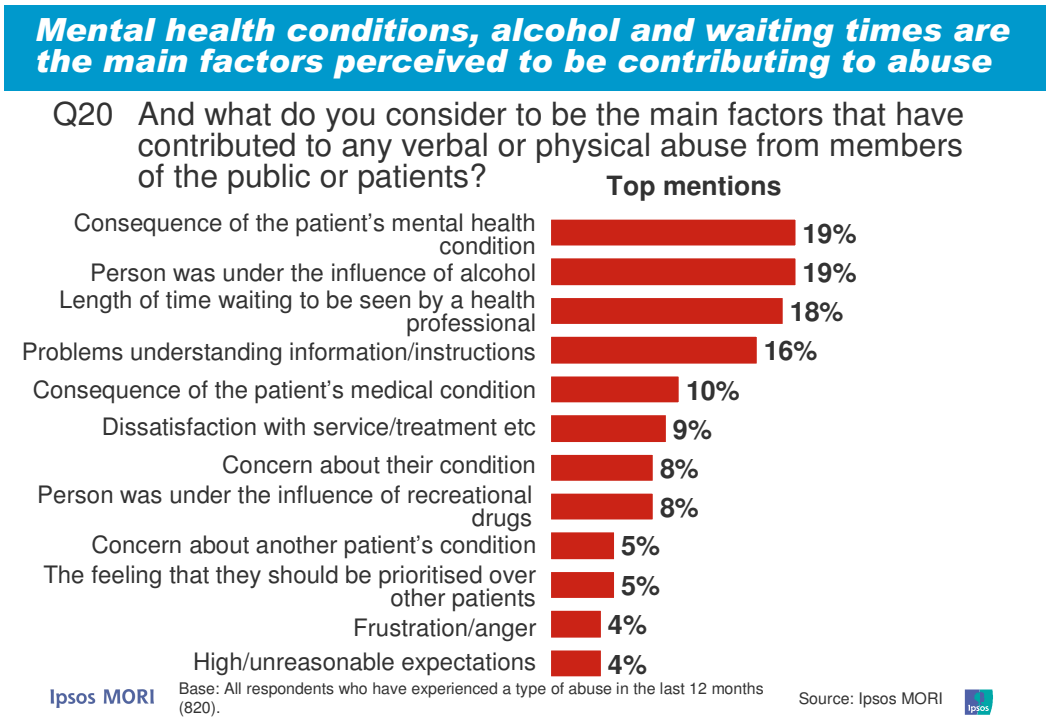
5.4 Perceptions on the Causes of Verbal Abuse/Threats and Physical Assault

The patient's mental health condition, the influence of alcohol and the length of wait to be seen by a health professional are perceived to be the main factors which contribute to abuse

When asked to consider the main factors that have contributed to verbal or physical abuse staff have experienced from members of the public or patients, the most cited reasons were 'as a consequence of the patient's mental health condition' and 'the person was under the influence of alcohol' (19% for both). With A&E staff considerably more likely than the average to experience verbal and physical abuse in the workplace, it is not surprising that the influence of alcohol is one of the main contributory factors.

Other top mentions include 'the length of time waiting to be seen by a health professional' and 'problems understanding information/instructions' (18% and 16% respectively). While the length of time waiting can indeed be frustrating from a patient's perspective, Ipsos MORI has found in other research that clear communication and feedback on the expected waiting time, and reasons for the wait, can have a positive impact on patient's satisfaction. Additionally, this problem can be exacerbated if there are communication ambiguities and misunderstandings.

Figure 29



Despite the small base sizes it is appropriate that **A&E staff**, both doctors and nurses, are significantly more likely to say that the verbal abuse or physical assault they experienced was as a consequence of the perpetrator being under the influence of alcohol.

As would be expected, those working in **mental health and learning disability organisations** (50%), compared to those in **primary care** (14%) and **acute care** (12%), are significantly more likely to say that the abuse they experienced was as a consequence of the patient's mental health condition.

Other points of note are the 'length of time waiting to be seen by a health professional' and 'the person was under the influence of alcohol' – both of these are significantly more likely to be a factor for staff in acute care.

Figure 30 indicates the top reasons given by staff split by the three main types of organisation, with significant differences between Trust types highlighted.

Figure 30

Reasons for not reporting verbal abuse – by Trust

		Trust type		
Most common reasons for not reporting verbal abuse…..	**Total** *(499)*	**Acute** *(211)*	**Primary care** *(212)*	**Mental health** *(69*)*
	%	%	%	%
Used to it/part of the job	37	35	34	**52**
Situation was resolved/not serious enough	28	27	30	30
Time required to file a report	13	**19**	10	4
Sympathy for patient or a relative –patient was anxious/upset	11	12	13	3
Incident was a result of the patient's clinical condition	11	12	8	14
Didn't think any action would be taken	10	13	11	3
Patient was under the influence of alcohol/ drugs	3	5	3	-
I am the person it would have been reported to	1	1	*	1
Did not want to pursue for other reason	9	9	10	3

Ipsos MORI

* N.B. Low base size

Response to Violence

Response to Violence

A key factor in how NHS staff judge their employer's commitment to their safety and security in the workplace is through the provision of a satisfactory response to an incident of verbal or physical abuse. The first step is in the reporting of the incident; knowing the channels and completing the appropriate incident reports. Once this has been completed, the onus is then on the employer to deal with the issue on behalf of the victim. This section will cover staff views and behaviours throughout the response process.

6.1 Reporting Incidents of Verbal Abuse/Threats and Physical Assault

Significant numbers of staff are not reporting incidents of abuse

The findings show a significant number of staff are not reporting incidents of verbal abuse or physical assault they have experienced (36% and 21% respectively). We will explore the reasons staff provide for non-reporting later.

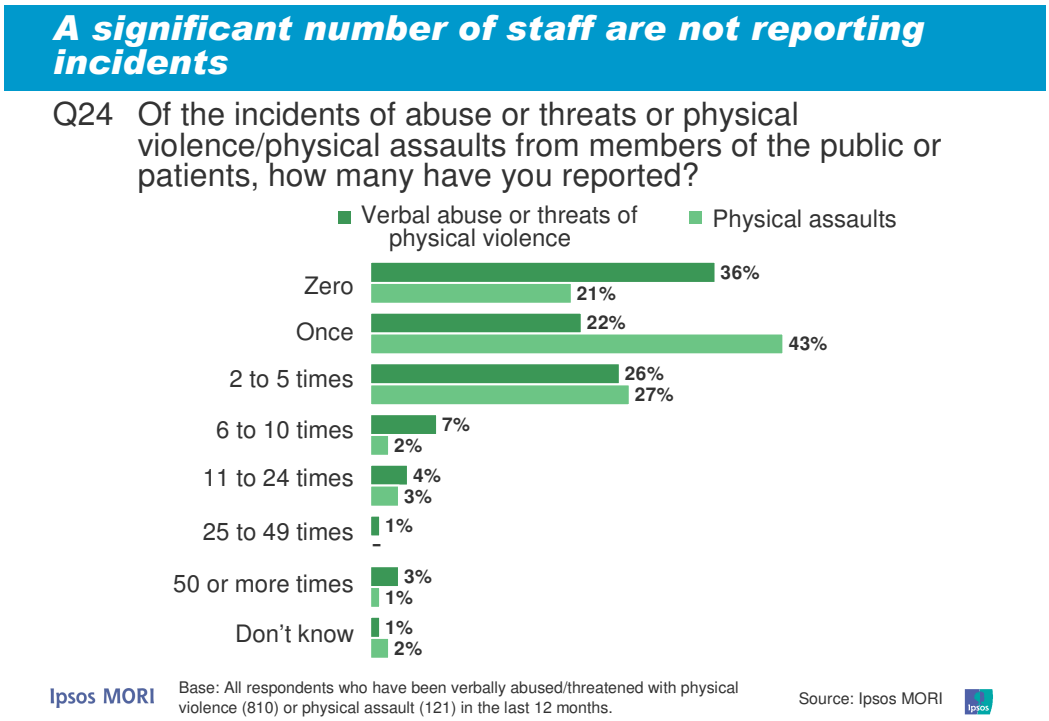
One in five (22%) say they have reported an incident of verbal abuse on one occasion, while nearly double this proportion (43%) say they have reported an incident of physical assault – no doubt reflecting their perceptions of the seriousness of such incidents. Just one in five say they have reported incidents of verbal abuse and physical assault on two to five occasions (26% and 27% respectively).

As would be expected, only a small proportion of staff are reporting more than ten incidents – those most likely to be in the 'at risk groups'.

The findings are broadly in line with the Care Quality Commission staff survey in terms of the numbers who are not reporting abuse[10].

[10] Comparisons between the NHS Security Management Service research and the Care Quality Commission staff research should be treated as indicative. This is due to the methodological and question format differences between the two surveys.

Figure 31



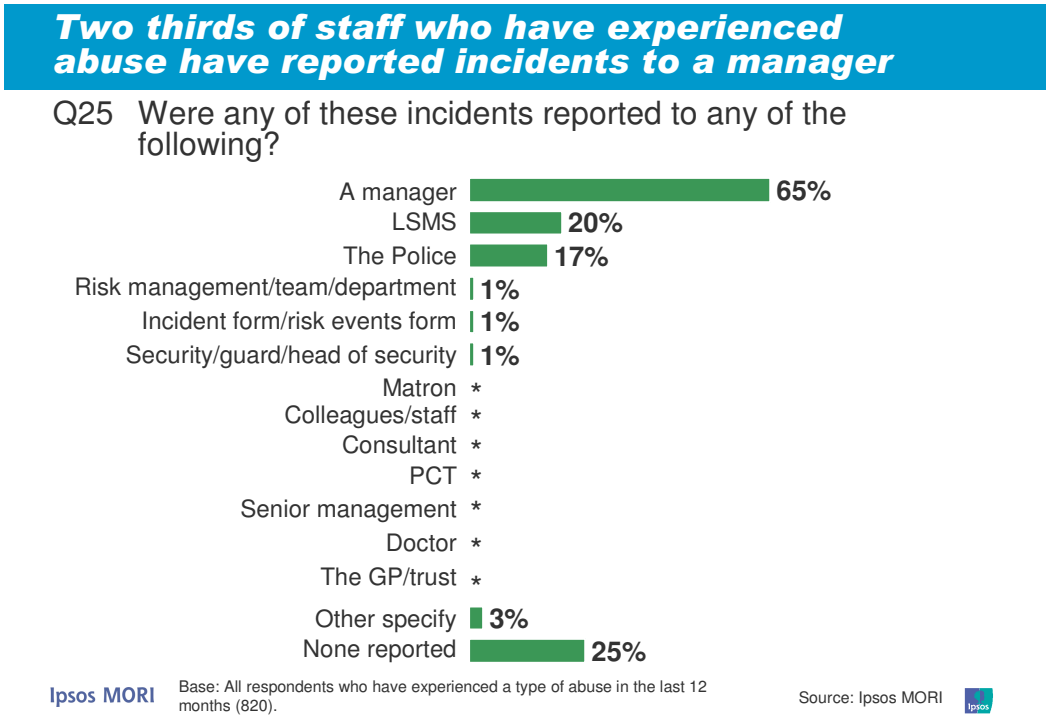
Those who have **never attended CRT** (44%) are significantly more likely not to have reported any incidents of verbal abuse compared to both those who **have attended CRT in the last year** (25%).

6.2 Reporting Channels

Managers are the most common channel for reporting an incident of abuse

Two in three (65%) of staff say they reported incidents to a manager, followed by one in five (20%) to their LSMS and seventeen per cent to the police. This shows that staff tend to report incidents to those in a position of authority who they regularly have access to in the first instance, before approaching the organisation's wider security specialists and then finally the authorities outside of the organisation. One in four (25%) have not reported any incidents.

Figure 32



Those working in **acute care** (27%) are significantly more likely than those working in **primary care** (14%) to say they reported an incident of abuse to an LSMS.

Staff who **have attended CRT** in the last year are significantly more likely to report an incident of abuse to a LSMS compared to **the average** (30% and 20% respectively).

The same staff groups are also significantly more likely to report an incident to a manager than the average (75% and 65% respectively).

Additionally, those who say they '**know something**' about each of the NHS Security Management Service initiatives (e.g. PARS, CRT, LSMS) are significantly more likely than those who '**know almost nothing/never heard of**' each initiative to report an incident to LSMS.

6.3 Reason for Non-Reporting

Being 'used to it' and considering a situation resolved or not serious enough are the main reasons why staff are not reporting verbal abuse

As suggested earlier in the report there seems to be a core group of NHS staff who are accepting of verbal and physical abuse as part of their job. Of those who did not report any incidents of abuse, approaching four in ten (37%) say the reason for this is that they are 'used to it/part of their job'. Over one in four (28%) say the situation was 'resolved/not serious

enough'. While this may be perceived as an acceptable outcome for the member of staff, it does not necessarily mean the outcome is acceptable for the NHS – particularly as a sizable minority of staff appear quite 'thick skinned' when faced with these issues.

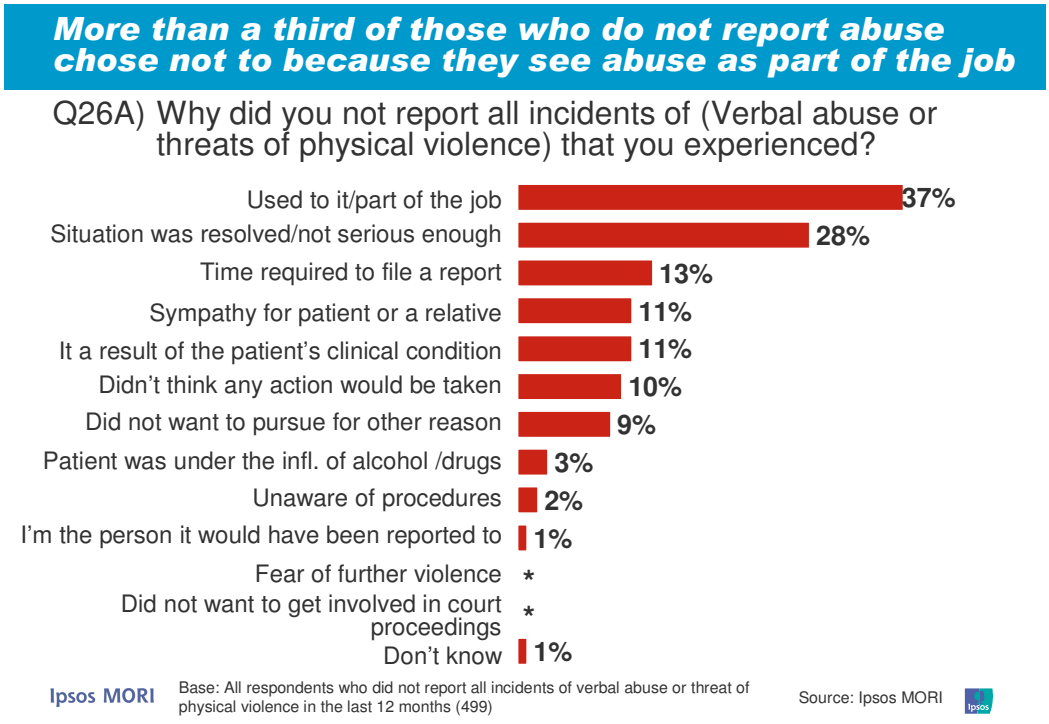
Thirteen per cent of staff say they did not report an incident due to the time it takes to file an incident report. As this is an element of the response process that the NHS Security Management Service has some control over, perhaps it is worth reviewing how easy it is for staff to file such reports.

Additionally, one in ten staff say they did not report an incident for the following reasons:

- Sympathy for the patient or a relative – patient was anxious/upset (11%);
- The incident was the result of the patient's clinical condition (11%);
- Didn't think any action would be taken (10%);
- Didn't want to pursue for another reason (9%).

Figure 33 shows the other top mentions given by staff for not conforming to the reporting process after experiencing an incident of verbal abuse.

Figure 33



Those working for **mental health and learning disability organisations** (52%) are significantly more likely than those working in **primary care** (35%), **acute care** (34%) to say

they did not report an incident of verbal abuse because they are 'used to it/part of the job'. However, due to a small base size of mental health staff, this should be treated with caution.

Staff **working both during the day and at night** (18%) are twice as likely as those just **working during the day** (9%) to say they did not file a report because of the time it would take to complete.

The only other difference of note between the types of organisation is staff in **acute care** (19%) are significantly more likely than both those in **primary care** (10%), and **mental health organisations** (4%), to say 'time required to file a report' is the reason why they did not file an incident report for the verbal abuse they experienced (as highlighted in Figure 34 below).

Figure 34 demonstrates how the reasons given for not reporting verbal abuse are split by organisation type.

Figure 34

Reasons for not reporting verbal abuse – by Trust

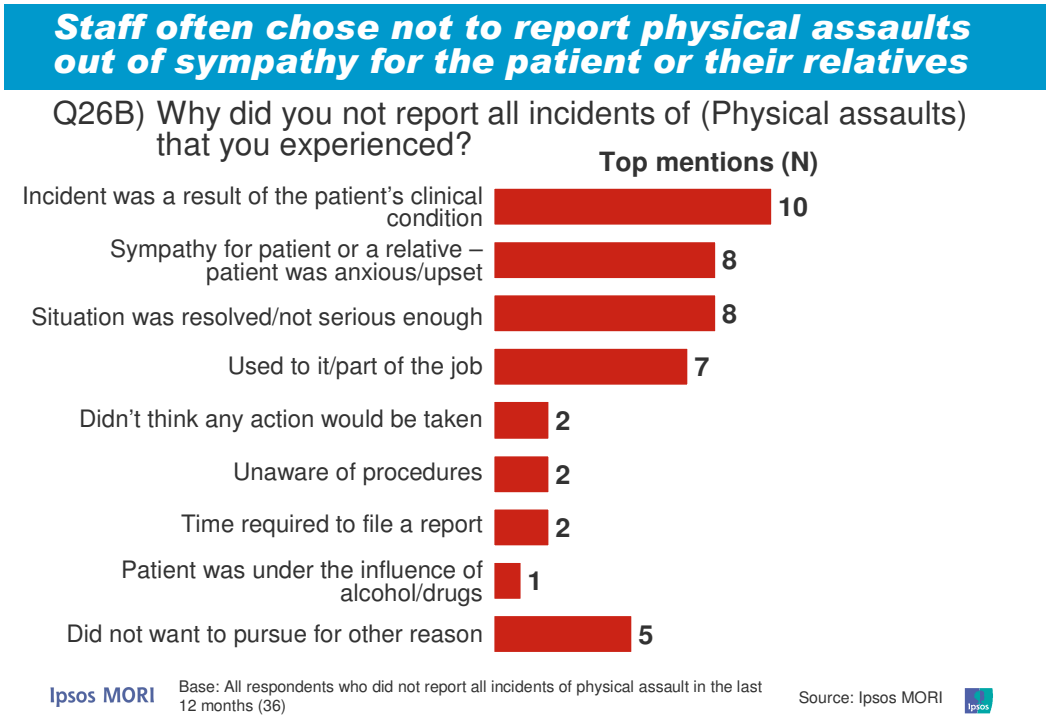
		Trust type		
Most common reasons for not reporting verbal abuse…..	**Total** *(499)*	**Acute** *(211)*	**Primary care** *(212)*	**Mental health** *(69*)*
	%	%	%	%
Used to it/part of the job	37	35	34	**52**
Situation was resolved/not serious enough	28	27	30	30
Time required to file a report	13	**19**	10	4
Sympathy for patient or a relative –patient was anxious/upset	11	12	13	3
Incident was a result of the patient's clinical condition	11	12	8	14
Didn't think any action would be taken	10	13	11	3
Patient was under the influence of alcohol/ drugs	3	5	3	-
I am the person it would have been reported to	1	1	*	1
Did not want to pursue for other reason	9	9	10	3

Ipsos MORI

* N.B. Low base size

The majority of staff who experienced a physical assault reported it through one of the channels listed at question 25 (reporting channels used). Figure 35 shows the reasons cited by a total of 36 staff – a small base – who did not report an incident.

Figure 35



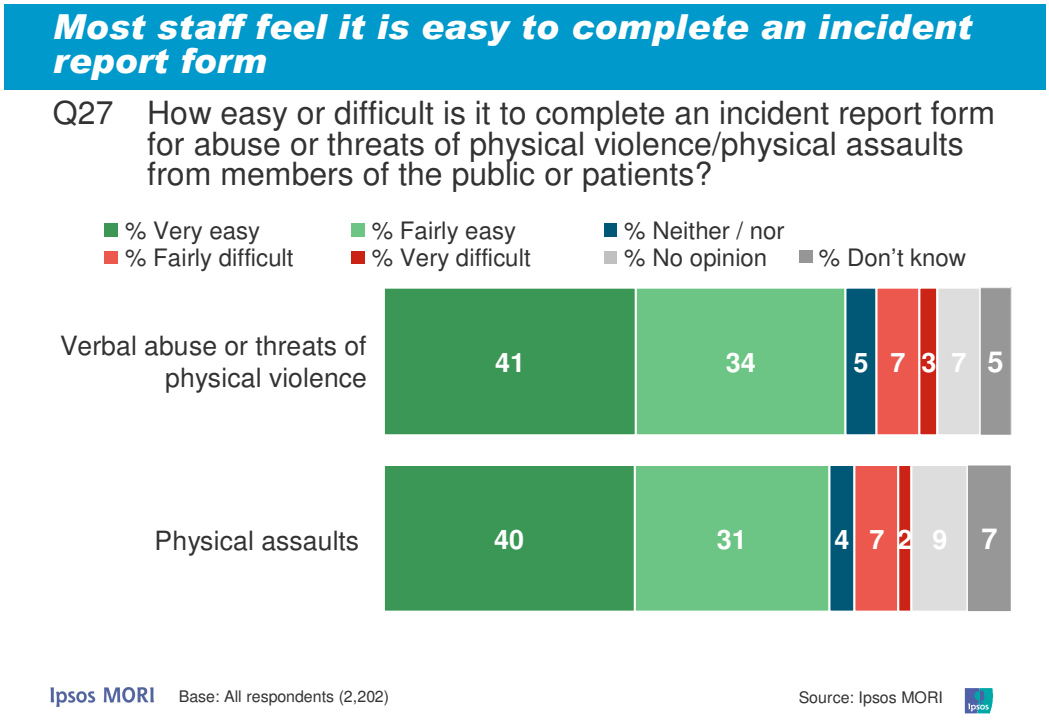
6.4 The Ease of Completing an Incident Report

The majority of staff consider filling out a report for incidents of verbal and physical abuse to be easy

With a number of staff not reporting an incident of verbal abuse or physical assault due to the time it takes to complete an incident report, it is worthwhile exploring how all staff perceive the ease with which a report can be completed.

Three in four staff (75%) say that incident reports are very easy/fairly easy to complete for incidents of verbal abuse or threats of physical violence. Seven in ten (71%) agree this is the case for incidents of physical assault. However, one in ten staff say that incident reports are very difficult/fairly difficult to complete (10% for verbal abuse and 9% for physical assault respectively). Considering this proportion in the context of the wider NHS workforce, a significant minority perceive the process to be difficult.

Figure 36



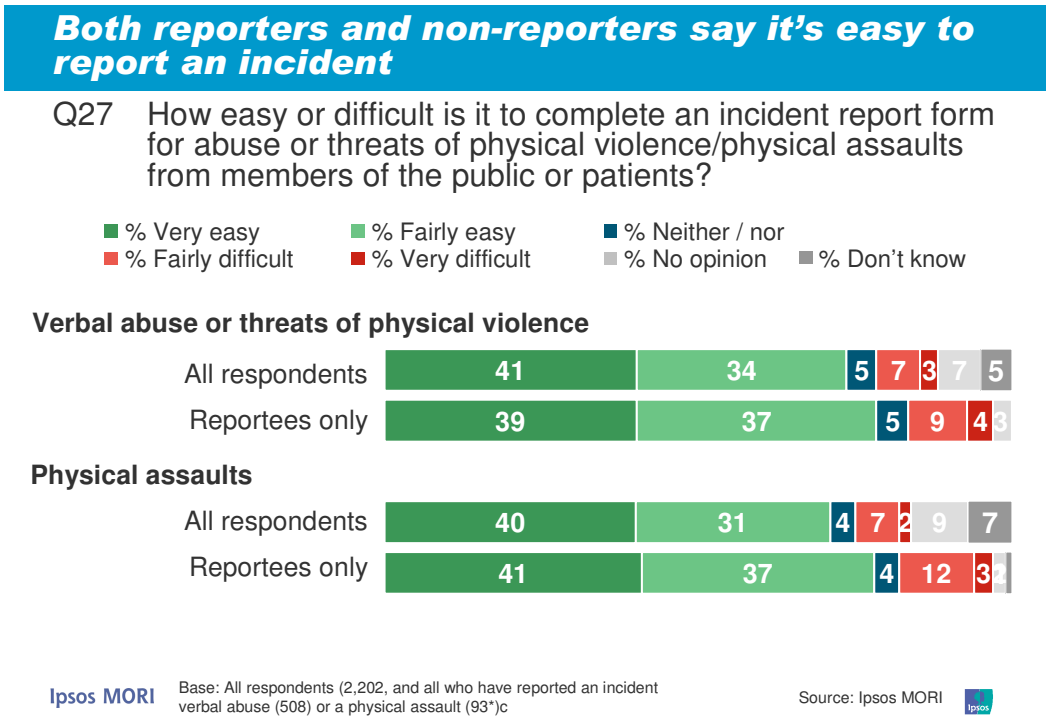
Those **who work alone** are significantly more likely to say that completing a report for incidents of verbal abuse is easy compared to those **who do not work alone** (76% and 71% respectively).

Staff who have **attended CRT in the last year** are also significantly more likely to say that it is easy to complete an report for incidents of verbal abuse compared to those who have **never attended the training** (83% and 66%).

Staff **working both day and night shifts** are significantly more likely than just those **working during the day** to say that it is easy to submit a report for incidents of physical abuse (76% and 69% respectively).

When the results are filtered to exclude those who have not completed a report, the findings are broadly in line with the views held by the wider NHS workforce. Slightly fewer respondents overall say that reporting an incident of verbal abuse or physical assault is fairly easy compared to those who have actually completed an incident report, but this difference is accounted for by an increase in those staff who say they 'don't know' or have 'no opinion' about the reporting process. See Figure 37 for details of how the views of reporters compare those of the respondents overall.

Figure 37



6.5 Views on the Reporting Process

More staff are positive about the process of reporting an incident of abuse compared to the benchmark survey, but they are less positive towards the outcome of a report

To gain an understanding of how staff view the reporting of incidents of verbal abuse and physical assault we asked a series of attitudinal questions on the process the NHS requires them to complete. Four of the five statements were originally asked in 2004, and this allowed us to benchmark the change in staff opinion over the interim period.

Figures 38 and 39 demonstrate the full breakdown of the results at each of the statements by the agreement scales. For ease, here is an overview of percentage point changes for combined agreement (either strong or moderate) among the results given by the 2009 benchmark groups compared to those recorded in 2004:

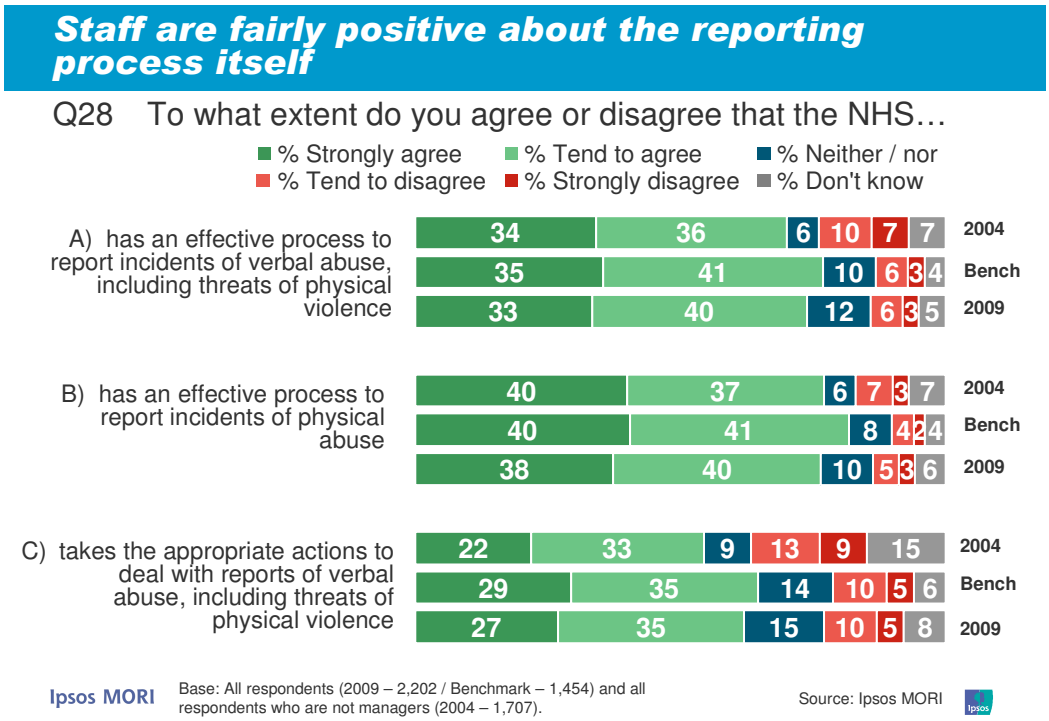
- 81% agree the NHS has an effective process to report incidents of physical abuse (up 4 percentage points since 2004);
- 76% agree the NHS has an effective process to report incidents of verbal abuse, including threats of physical violence (up 6 percentage points);

- 69% agree the NHS takes appropriate actions to deal with reports of physical abuse (up 9 percentage points);

- 64% agree the NHS takes the appropriate actions to deal with reports of verbal abuse, including threats of physical violence (up 9 percentage points).

While these results show an upward trend in satisfaction among the benchmarked staff groups, there is still work to be done in the delivery of a satisfactory outcome for the victim of verbal abuse or physical assault. Only around half (47%) of all staff say that reporting an incident of verbal or physical assault leads to a satisfactory outcome – a figure that the NHS Security Management Service will undoubtedly seek to improve in the coming years.

Figure 38

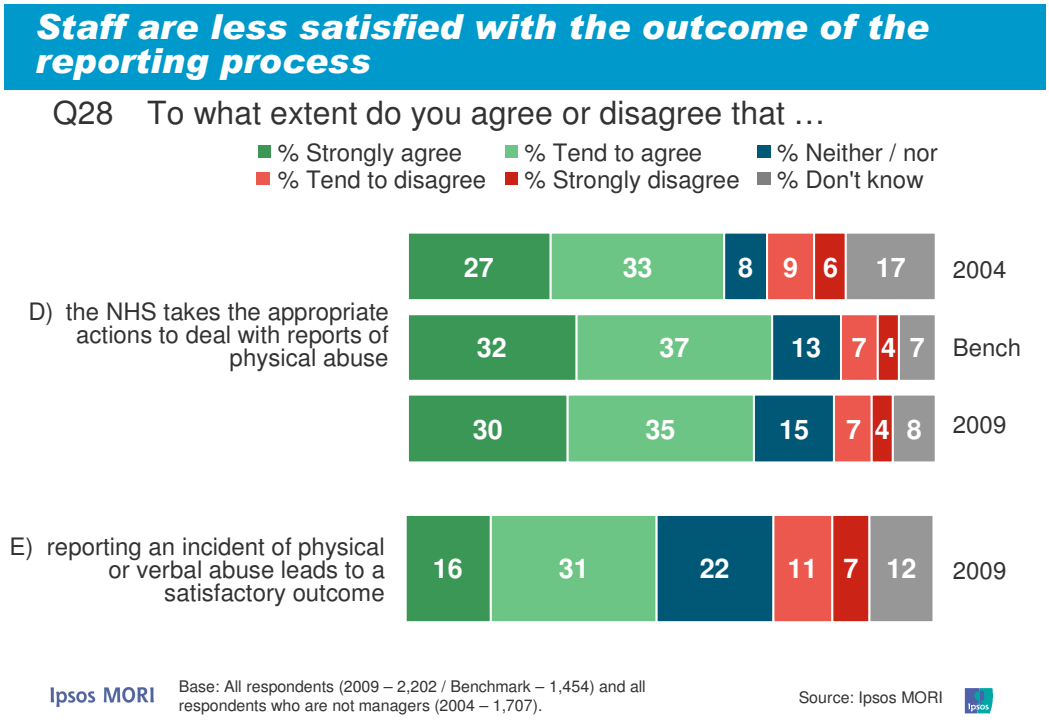


Those working for **mental health and learning disability organisations** (82%) are more likely than those working in **acute care** (75%) or **primary care** (70%) to agree that the NHS has an effective process for reporting incidents of verbal abuse;

Women are more likely than **men** to agree that the NHS has an effective process to report incidents of physical abuse (79% and 74% respectively);

This trend is also prevalent for the statement 'the NHS takes appropriate actions to deal with reports of verbal abuse, including threats of physical violence' – **women** are more likely to agree compared to **men** (63% and 58% respectively).

Figure 39



Those **who have not been victims of abuse in the last twelve months** (68%) are more likely to agree that the NHS takes the appropriate actions to deal with reports of physical abuse' compared to **those who have experienced verbal abuse** (62%) and **physical abuse** (60%);

Reinforcing the trend, those who have attended **CRT in the last 12 months** (58%) are more likely than those who have attended it between **one and three years ago** (49%), **over three years ago** (44%), and **those who have never attended it** (41%) to say reporting an incident of verbal or physical abuse leads to a satisfactory outcome.

We also filtered the results to compare the overall respondent views to only those who have reported either an incident of verbal abuse or physical assault. The findings again suggest remarkably little difference between the views of the reporters and those of the wider frontline staff – indicating that direct experience of the NHS reporting process has no significant impact on how effective staff perceive it to be.

Figures 40 and 41 show the responses for each of the attitudinal statements by both the overall responses and those of reporters.

Figure 40

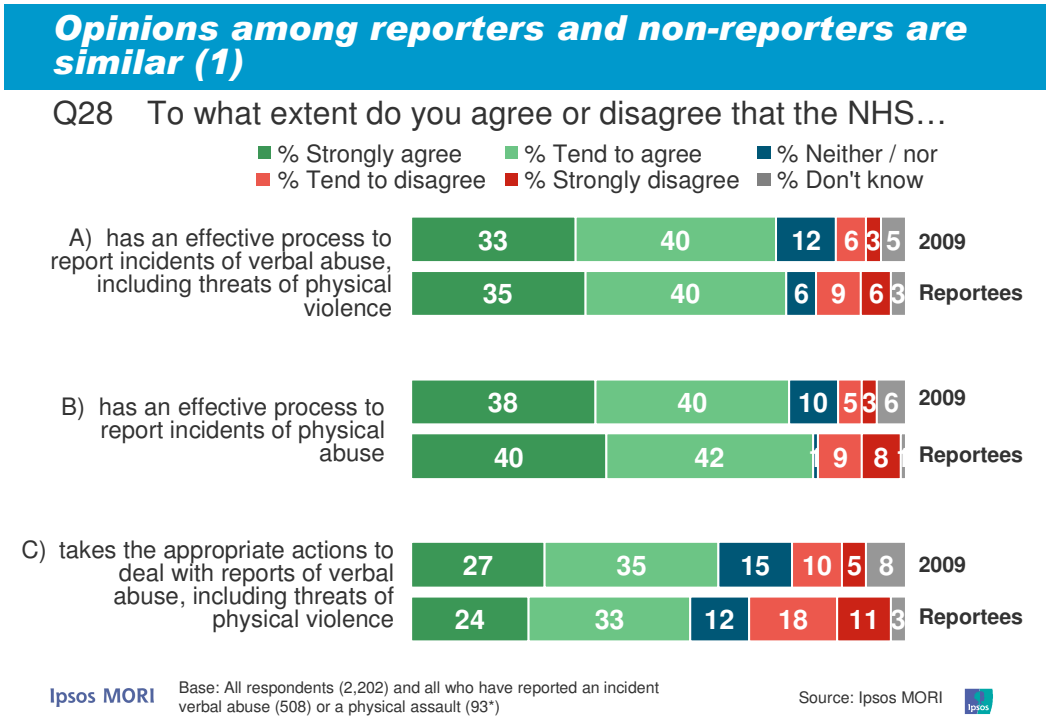
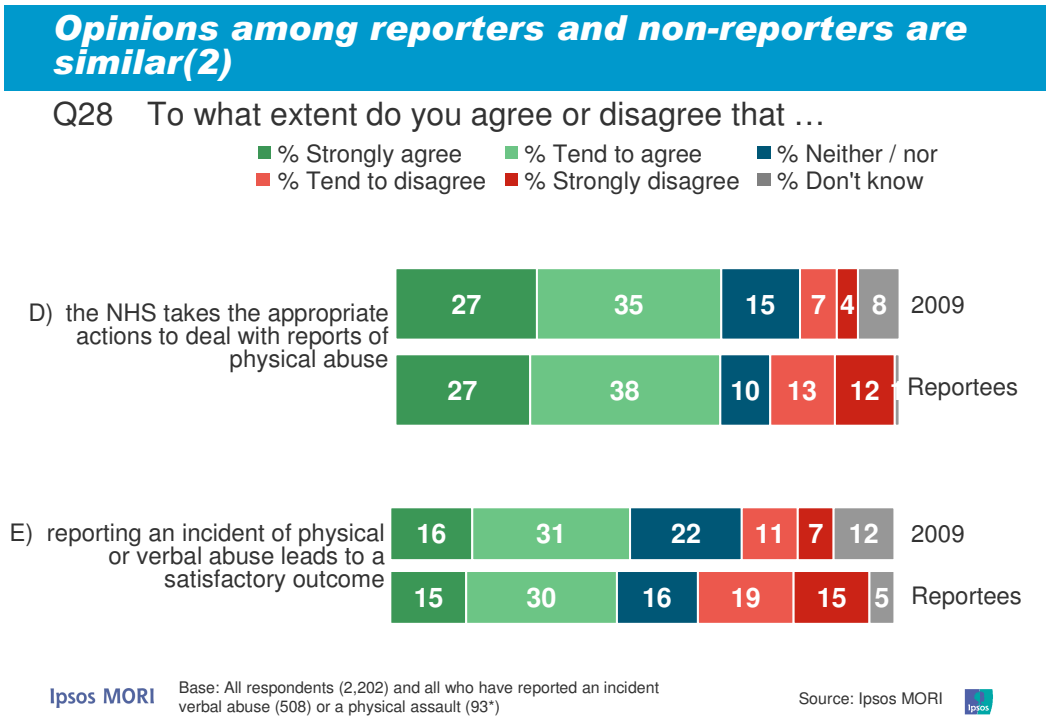


Figure 41



6.6 Satisfaction with the Outcome of a Report

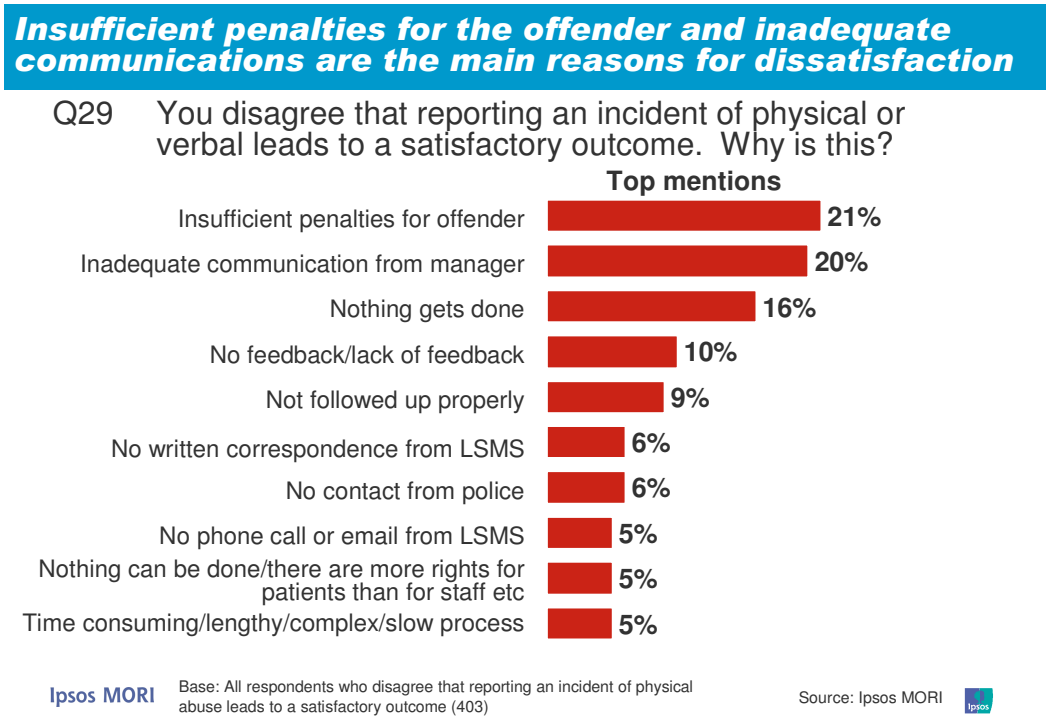
Insufficient penalties for the offender and inadequate communication from manager are the main reasons for dissatisfaction with reporting outcomes

To help identify the potential ways the NHS can increase staff satisfaction towards the outcome of a report of verbal abuse or physical assault, we asked those who disagree that reporting an incident leads to a satisfactory outcome to explain the reasons for their response.

Around one in five say the reason is 'insufficient penalties for the offender' and 'inadequate communication from a manager' (21% and 20% respectively). This is followed by sixteen per cent who say that 'nothing gets done', while a further one in ten (9%) feel the incidents are 'not followed up properly'.

The findings demonstrate a sense of apathy among some staff towards the reporting process – three of the top five responses are reflective of the view that little is done to either penalise the offender or make changes to prevent such incidents from occurring again. It also appears that there is a lack of feedback/communication following reported incidents.

Figure 42



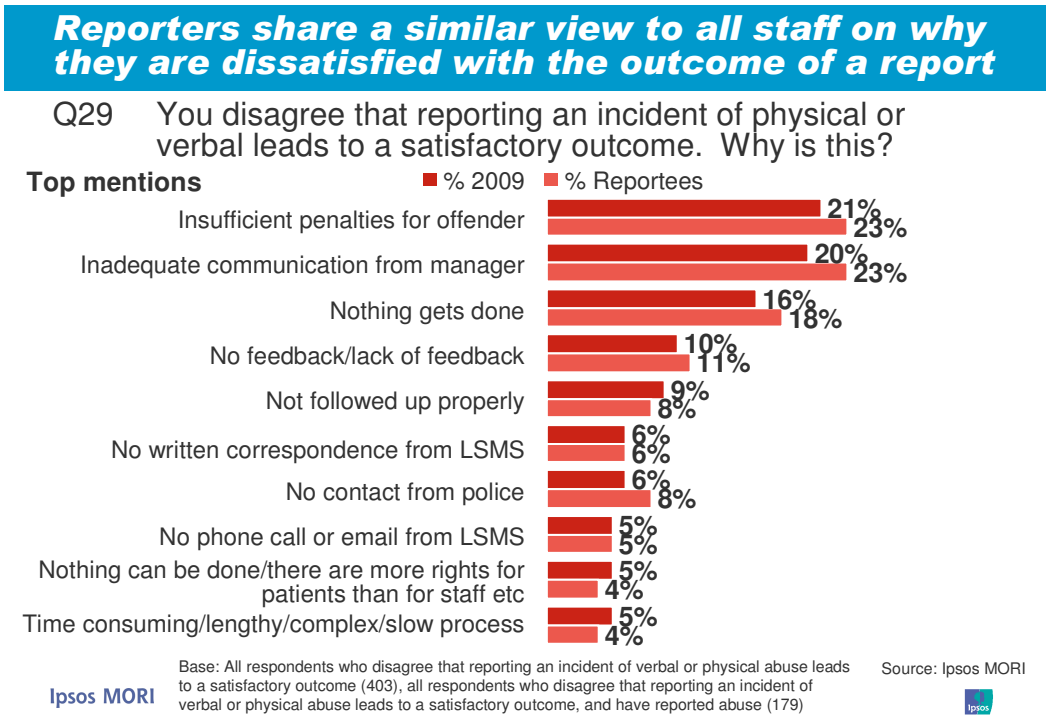
Staff who **work during both the day and the night**, compared to those who just **work during the day**, are more likely to say insufficient penalties for the offender is the main

reason why they disagree that reporting an incident leads to a satisfactory outcome (26% and 17% respectively);

Women are significantly more likely than **men** to say inadequate communication from a manager is the reason why they disagree reporting an incident leads to a satisfactory outcome (23% and 13% respectively).

When filtered by only those who have reported abuse, the results remain very similar to those respondents overall who disagree that reporting an incident of physical or verbal abuse leads to a satisfactory outcome. Again, this reinforces the trend that the views of those who have experienced abuse and completed an incident report are very similar to those of all respondents.

Figure 43



Improving Safety

Improving Safety

Meeting the personal safety and wellbeing expectations of staff is one of the priorities for the NHS Security Management Service as it seeks to increase security across the health service in both real terms and perceived terms. In this final section we will explore some of the priorities that staff feel will make their workplace a safer and more secure working environment.

7.1 Staff Priorities on Safety in their Organisation

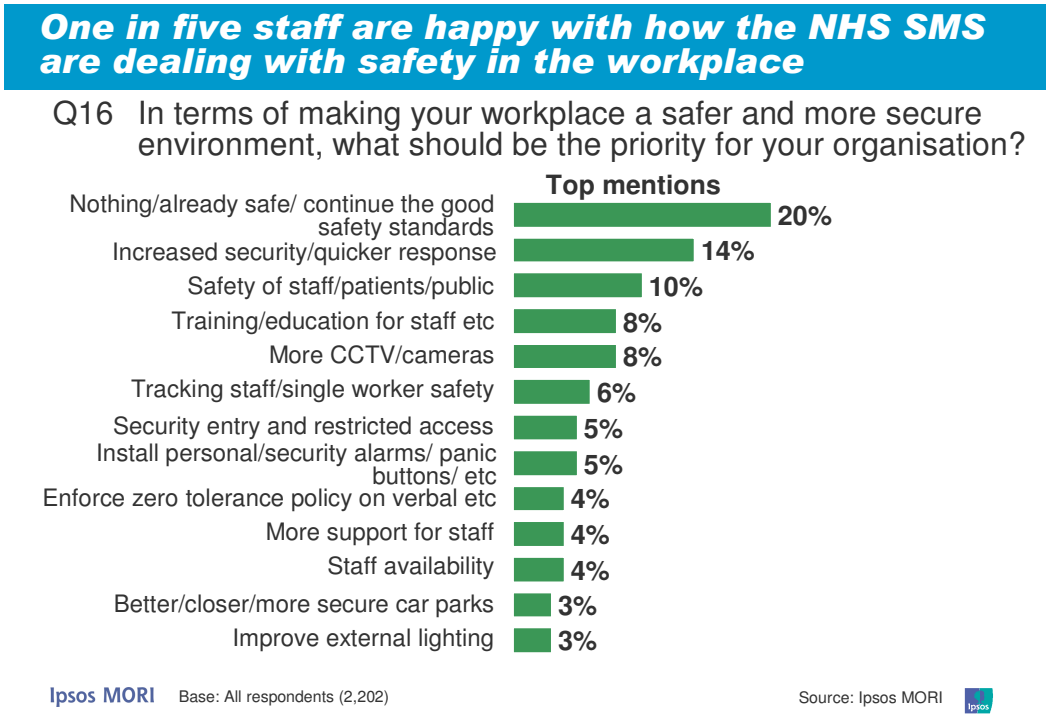
A quicker response and increased training/education are considered by staff to be priorities for improvements to safety

In some ways it is encouraging that one in five staff (20%) say 'nothing/already safe/continue the good safety standards' when asked about the priorities for future improvements – the largest coded response. However, there was a range of comments provided by the majority of staff on how their workplace could be made a safer and more secure environment. Of these suggested priorities, the most frequent mentions include:

- Increased security/quicker response (14%);
- Safety of staff/patients/public (10%);
- Training/education of staff etc (8%);
- More CCTV/cameras (8%);
- Tracking staff/single worker safety (6%).

There are no specific themes linking the most cited priorities, rather staff indicate a range of approaches are required to make their workplace more safe and secure. While an increased security presence/response and more CCTV are both mentioned as ways potential ways to improve the safety, neither of these where considered by staff to make them feel particularly safe while at work. With lone worker safety/polices and CRT as the initiatives that staff say make them feel more secure in their place of work, it is perhaps of no surprise that 'training/education of staff' and 'tracking staff/single worker safety' appear in the list of top mentions.

Figure 44



It is evident that there is no quick fix to increasing the perception of security among the frontline NHS workforce, just as there is no quick fix to improving the actual levels of verbal abuse and physical assault experienced by staff. Nevertheless, the findings here demonstrate the devil is in the detail. Continuous monitoring and improvements to each of the security areas covered in this research will no doubt lead to the increased perception among frontline staff groups that they are being effectively supported by their employers, and can continue to focus their efforts on delivering high quality treatment and care.

Appendices

Appendices

Letter to NHS HR Departments / SMDs

NHS Security Management Service (NHS SMS) October 2009

Gateway Reference SMS/MOR/J37160

ROCR reference: **ROCR-Lite/09/0020**

From: **Richard Hampton**

Head of Security Management – NHS Security Management Service

To: **(JOB TITLE, ORGNAME)**

cc: **NHS Directors of Human Resources**
Designated NHS Security Management Directors

Ipsos MORI / NHS SMS survey of NHS frontline staff

This memo informs you of a poll to be conducted by the NHS Security Management Service which may affect staff at your trust. It explains the background, objectives and methodology of the poll.

Background and objectives

In April 2003, the NHS Security Management Service (NHS SMS) was established with the aim of protecting the NHS so that it can better protect the public's health. The NHS SMS has responsibility for all policy and operational matters relating to the management of security in the NHS.

The NHS SMS is committed to the delivery of an environment for those who use or work in the NHS that is properly secure so that the highest possible standard of clinical care can be made available to patients. This involves work in a number of different areas,

including protecting staff and professionals from violence, protecting property and assets, security of controlled drugs and the security of maternity and paediatric wards.

The document *A Professional Approach to Managing Security in the NHS*, available at www.nhsbsa.nhs.uk/security, outlines how the NHS will provide the best possible protection for its staff, professionals, patients and property, developing initiatives across the whole of the generic range of action.

As part of our integrated approach to managing security, the NHS SMS is conducting a baseline survey to help identify the nature and scale of problems in this area and assess the attendant risks. This survey will allow us to track changes in perceptions of security and reported incidents over time.

Methodology

We aim to conduct a 12-minute telephone interview with NHS employees, including the following types of NHS staff:

- nurses
- doctors/consultants
- accident and emergency staff
- technicians
- porters
- security staff
- lone workers from acute trusts, GP practices, mental health trusts, ambulance trusts and primary care trusts.

A random sample of respondents from an NHS database will be used to ensure national coverage. We would also like to reassure you that everyone's details will be treated with the utmost confidentiality and that no information which could identify any one individual will leave Ipsos MORI.

The interviews will be carried out by Ipsos MORI Telephone Surveys using computer-assisted telephone interviewing (CATI) technology. The use of CATI in telephone research guarantees tight control over the fieldwork process through automatic monitoring of quotas and routing in the questionnaire, and on-screen flagging of appointments. This ensures that the time taken will be kept to a minimum.

The fieldwork will be carried out during November and December 2009, and will target approximately 2000 staff across the NHS. As a result, staff at your trust may receive phone calls from Ipsos MORI asking them to take part in the interviews. Should they have any concerns, please direct them to www.nhsbsa.nhs.uk/security, where they will be able to access the information contained in this memo.

If you require any additional information about the research, please contact Clare Fletcher, Senior Research Officer at the NHS SMS, by phone: 020 7895 4623, or by

email: clare.fletcher@cfsms.gsi.gov.uk or Chris Marshall, Research Executive at Ipsos MORI, by phone: 020 7347 3486, or by email:chris.marshall@ipsos.com.

Yours faithfully,

Richard Hampton
Head of Security Management, NHS SMS

Ipsos MORI

NHS

Security Management Service

Marked-Up Questionnaire

Ipsos MORI/J37160/CM/VK/AC

NHS SMS Safety in the Workplace
Final Topline Results
01-02-10

- Results are based on 2,202 interviews with NHS frontline health professionals, conducted by Computer Assisted Telephone Interviewing (CATI) between 13 November and 18 December 2009;
- The 2009 data are unweighted;
- All figures given in percentages are based on the total sample of key frontline NHS health professionals (2,202) unless otherwise stated;
- The benchmark results from the 2009 survey are based on a sample size of 1,454 key frontline health professionals, excluding those who have been in their role for less than 1 year and weighted to reflect the sample from 2004;
- The benchmark results from the 2004 survey are based on a sample size of 1,811 key frontline NHS health professionals, interviewed by telephone between 28 April and 24 May 2004;
- Where percentages do not sum to 100, this is due to computer rounding, the exclusion of 'don't know' categories, or multiple answers.
- Where question base sizes are below 100 interviews, the precise number of responses are given instead of percentages;
- An asterisk (*) denotes any value of less than 0.5% but greater than zero.

CORE QUESTIONNAIRE

BASE: ALL RESPONDENTS WHO ARE NOT MANAGERS, 2,101

Q1. **Does your job involve interacting with patients or members of the public?** UNPROMPTED. SINGLE CODE ONLY.

	%
Yes	100
No	-

BASE: ALL RESPONDENTS WHO ARE NOT MANAGERS, 2,101

Q2. **Are you a student?** UNPROMPTED. SINGLE CODE ONLY.

	%
Yes	-
No	100

BASE: ALL RESPONDENTS

Q3. **How long have you been in your current position at** [INSERT ROLE]**?** UNPROMPTED. SINGLE CODE ONLY.

	2009	2009 BENCHMARK	2004
	%	%	%
Less than 1 year[11]	16	N/A	N/A
1 year but less than 2 years	14	18	20
2 years but less than 5 years	22	25	31
5 years but less than 10 years	25	31	20
10 years or more	23	26	29

[11] 'Less than 1 year' was not listed as a code 2004. NHS health professionals with less than one year experience were filtered out of the sample.

Q4. **Including any previous employers, how long have you been working as a** [INSERT ROLE]? UNPROMPTED. SINGLE CODE ONLY.

	%
1 year but less than 2 years	8
2 years but less than 5 years	13
5 years but less than 10 years	23
10 years or more	55
Don't know	*

Q5. **Which of the following best describes the type of organisation you work for?** READ LIST. SINGLE CODE ONLY.

	%
Primary care trust	32
Acute trust	29
Mental health trust	13
GP practice	9
Community hospital/polyclinic/walk-in centre	5
Dental practice	4
Optician	4
Foundation trust	1
Pharmacy	*
Ambulance Service	*
Tertiary care trust	*
Teaching centre	*
General hospital	*
Residential hospital/trust	*
Hospital trust	*
NHS trust	*
Other	1

Q6. **In which one of the following areas do you primarily work?** PROMPTED LIST. SINGLE CODE ONLY.

	%
Primary Care	30
Mental health	12
A&E	8
Older adults	6
Outpatients	5
Obstetrics/Gynaecology	4
Patient relations/PALS	4
Paediatric/Child and Adolescent	3
Optics	2
Genito Urinary Medicine (GUM)	2
General medicine	2
Dental	2
Maternity	2
Learning Disability	1
Reception/administration	1
Community based/service	1
Pharmacy	1
Cardiology	1
Security	1
Acute Medicine	1
Inpatients	*

Surgery/Surgeon	*
Estates/Facilities	*
Substance Misuse/Drug and Alcohol	*
Orthopaedic	*
Renal	*
Management/ planning/ strategy	*
Rehabilitation	*
HR/ training	*
Trust/ Trust Head office/ Trust board	*
Portering	*
Oncology	*
Corporate offices/ department	*
Governance	*
Dietician/ Nutrition	*
Minor injury unit	*
Commissioning	*
Palliative care	*
Radiology	*
Neurology	*
Intensive care unit	*
Diabetes	*
Respiratory ward	*
Risk management	*
Public health	*
Physiotherapy	*
Medical admissions	*
Dermatology	*
Mortuary	*
Acute care	*
Haematology	*
Children and community service	*
ENT	*
No specific area/ all sections	2
Other	3
No answer	*

Q7. **Do you ever work alone ?**
DO NOT READ OUT. SINGLE CODE ONLY.

		%
A	Yes	69
B	No	31
C	Not stated	*

BASE: ALL RESPONDENTS WHO WORK ALONE (CODED 1 AT Q7), 1,510

Q8. **How secure, if at all, do feel when working alone? Do you feel…**
DO NOT READ OUT. SINGLE CODE ONLY.

	%
Very secure	44
Fairly secure	50
Not very secure	4
Not at all secure	1
Neither	1
Don't know	*

BASE: ALL RESPONDENTS

Q9. **Do you work …. ?**

READ OUT. SINGLE CODE ONLY.

	%
During the day	67
During the night	*
Both	33

Q10. **Thinking about the areas you work in, where you are dealing with patients and members of the public, how good or poor are each of the following…**

READ OUT STATEMENTS (ROTATED). SINGLE CODE ONLY FOR EACH.

	Very good	Fairly good	Neither good nor poor	Fairly poor	Very poor	N/A	Don't know	None
	%	%	%	%	%	%	%	%
Working temperature	28	40	9	13	6	4	*	*
Quality of lighting	46	37	6	6	1	3	*	*
The level of noise	27	42	11	12	3	4	1	*
The number of people in close proximity/ overcrowding	30	35	9	13	5	7	1	*
The presence of CCTV cameras	14	22	8	11	11	27	5	*
The availability of seating for patients and the public	41	36	4	6	2	10	*	*
Provision of patient waiting time information	24	32	6	9	4	22	4	*
Provision of refreshments	22	28	7	11	9	23	1	*
Provision of TV or reading material eg magazines and newspapers	23	33	7	12	6	18	1	*
Provision of smoking areas	10	9	3	5	12	59	2	*
Availability of private areas	27	34	6	15	6	11	1	*

Q11. **Please tell me whether you know a lot, a fair amount, a little, almost nothing or have never heard of any of the following initiatives to help support employees in dealing with violence in the workplace.** READ OUT STATEMENTS (ROTATED). SINGLE CODE FOR EACH.

		A lot	A fair amount	A little	Almost nothing	Never heard of/don't know
		%	%	%	%	%
A	Security Awareness Month (SAM)	6	12	15	8	59
B	Your trust Local Security Management Specialists (LSMS)	12	18	17	7	46
C	Your trust Security Management Director (SMD)	8	13	16	9	54
D	The SMS 'Secure' newsletter	3	6	10	5	75
E	Local Violence/security/lone-worker policies and procedures	22	29	20	5	23
F	Local Reporting procedures (PARS)	26	29	17	4	22
G	Trust Conflict Resolution Training (CRT)	31	25	18	6	20
H	Legal Protection Unit (LPU)	6	14	21	8	51
I	Promoting Safer and Therapeutic Services (CRT for mental health)	6	11	18	8	57

2009 BASE: ALL RESPONDENTS
2009 BENCHMARK BASE: ALL RESPONDENTS
2004 BASE: ALL NHS HEALTH PROFESSIONALS WHO ARE NOT MANAGERS, 1,707

Q11 (B). **Please tell me whether you know a lot, a fair amount, a little, almost nothing or have never heard of any of the following initiatives to help support employees in dealing with violence in the workplace. (Your trust Local Security Management Specialists (LSMS))** READ OUT A-I. ROTATE ORDER. SINGLE CODE FOR EACH.

	2009	2009 BENCHMARK	2004
	%	%	%
A lot	12	13	2
A fair amount	18	20	6
A little	17	19	16
Almost nothing	7	7	9
Never heard of/don't know	46	41	67

2009 BASE: ALL RESPONDENTS
2009 BENCHMARK BASE: ALL RESPONDENTS
2004 BASE: ALL NHS HEALTH PROFESSIONALS WHO ARE NOT MANAGERS, 1,707

Q11 (G). **Please tell me whether you know a lot, a fair amount, a little, almost nothing or have never heard of any of the following initiatives to help support employees in dealing with violence in the workplace. (Trust Conflict Resolution Training (CRT))** READ OUT A-I. ROTATE ORDER. SINGLE CODE FOR EACH.

	2009	2009 BENCHMARK	2004
	%	%	%
A lot	31	34	4
A fair amount	25	28	13
A little	18	19	24
Almost nothing	6	6	13
Never heard of/don't know	20	14	47

2009 BASE: ALL RESPONDENTS
2009 BENCHMARK BASE: ALL RESPONDENTS
2004 BASE: ALL NHS HEALTH PROFESSIONALS WHO ARE NOT MANAGERS, 1,707
Q11 (H). **Please tell me whether you know a lot, a fair amount, a little, almost nothing or have never heard of any of the following initiatives to help support employees in dealing with violence in the workplace. (Legal Protection Unit (LPU)** READ OUT A-I. ROTATE ORDER. SINGLE CODE FOR EACH.

	2009	2009 BENCHMARK	2004
	%	%	%
A lot	6	6	1
A fair amount	14	15	4
A little	21	21	18
Almost nothing	8	8	14
Never heard of/don't know	51	50	64

BASE: ALL RESPONDENTS
Q12. **In addition to the SMS initiatives just outlined, can you tell me about any additional support your employer provides in terms of your personal safety and wellbeing while you are at work?** DO NOT PROMPT. MULTICODE OK.

	%
Other alarms (fixed emergency)	23
Security guards/officers	14
Mobile phone	13
Lone worker devices	10
Personal safety training	6
Secure entry system	6
CCTV	4
Register to sign in and out/report where we are going/when we are leaving/diary system	4
Working in pairs/within a team/never alone/lone worker policy	4
Staff support system	3
Reporting procedures (PARS)	2
Disengagement training (breakaway skills)	2
Building security	2
Dedicated security phone line/telephone service/walkie talkie/emergency number	2
Personal alarm/protective equipment	2
Other policies & procedures	2
Promoting safer and therapeutic services training	1
Physical intervention training (control and restraint)	1
Counselling service/course/emotional support for staff	1
Emails/posters/newsletter/leaflets/safety bulletins	1
ID cards/security badges/passes	1
Occupational health/health and safety policy/procedure/programme	1
Panic button	1
Police officer on site/liaison with police	1
Safe car parking	1
Security lights/outdoor lighting	1
Torch	*
Whistle	*

Armour vests	*
Code words/security codes	*
Contact porter/porter helps out when needed	*
Exits/alternative exits	*
Fire safety/training	*
Lockers for staffs personal items	*
Meetings/discussions/debriefing	*
Special rooms for hard patients/for private conservations	*
Well staffed environment	*
Zero tolerance policy	*
Other	4
Don't know	3
None	30

BASE: ALL WHO GAVE A RESPONSE AT Q11 OR Q12, 2,104

Q13. **Which, if any, of the following initiatives and/ or support mechanisms have made you feel secure in your place of work?** ROTATE ORDER. MULTICODE OK.

	%
Local Violence/security/lone-worker policies and procedures	50
Trust Conflict Resolution Training (CRT)	49
Local Reporting procedures (PARS)	46
Your trust Local Security Management Specialists (LSMS)	29
Your trust Security Management Director (SMD)	21
Legal Protection Unit (LPU)	19
Other alarms (fixed emergency)	19
Security Awareness Month (SAM)	18
Promoting Safer and Therapeutic Services (CRT for mental health)	18
Security guards/officers	13
Mobile phone	12
The SMS 'Secure' newsletter	9
Lone worker devices	8
Secure entry system	6
Personal safety training	5
CCTV	4
Register to sign in and out/report where we are going/when we are leaving/diary system	4
Working in pairs/within a team/never alone/lone worker policy	4
Staff support system	3
Reporting procedures (PARS)	2
Disengagement training (breakaway skills)	2
Dedicated security phone line/telephone service/walkie talkie/emergency number	2
Personal alarm/protective equipment	2
Physical intervention training (control and restraint)	1

Building security	1
Counselling service/course/emotional support for staff	1
Emails/posters/newsletter/leaflets/ safety bulletins	1
ID cards/security badges/passes	1
Occupational health/health and safety policy/procedure/program	1
Panic button	1
Police officer on site/liaison with police	1
Risk Assessment	1
Safe car parking	1
Security lights/outdoor lighting	1
Other policies & procedures	1
Torch	*
Whistle	*
Promoting safer and therapeutic services training	*
Armour vests	*
Code words/security codes	*
Contact porter/porter helps out when needed	*
Exits/alternative exits	*
Fire safety/training	*
Lockers for staffs personal items	*
Meetings/discussions/debriefing	*
Special rooms for hard patients/for private conservations	*
Well staffed environment	*
Zero tolerance policy	*
Other	3
Not applicable	-
Don't know	*
None	12

BASE: ALL RESPONDENTS

Q14. **When, If at all, did you last attend Conflict Resolution Training? Was it …**
READ OUT LIST. SINGLE CODE.

	%
Less than a year ago	24
Between 1 and 3 years ago	27
Over 3 years ago	11
Never attended Conflict Resolution training	38
Don't know	1

2009 BASE: ALL RESPONDENTS
2009 BENCHMARK BASE: ALL RESPONDENTS
2004 BASE: ALL NHS HEALTH PROFESSIONALS WHO ARE NOT MANAGERS, 1,707
Q15 (A). **To what extent do you agree or disagree that your workplace provides a safe and secure working environment against (Verbal abuse or verbal threats of physical violence from the general public and patients)? Is that strongly or tend to agree/disagree?**[12]
FOR EACH STATEMENT, SINGLE CODE ONLY.

	2009	2009 BENCHMARK	2004
	%	%	%
Strongly agree	31	30	24
Tend to agree	39	40	39
Neither agree or disagree	13	13	8
Tend to disagree	9	10	17
Strongly disagree	5	5	10
Don't know[13]	1	1	N/A
None/ no opinion	*	-	2

2009 BASE: ALL RESPONDENTS
2009 BENCHMARK BASE: ALL RESPONDENTS
2004 BASE: ALL NHS HEALTH PROFESSIONALS WHO ARE NOT MANAGERS, 1,707
Q15 (B). **To what extent do you agree or disagree that your workplace provides a safe and secure working environment against (Physical violence from the general public and patients)? Is that strongly or tend to agree/disagree?**
FOR EACH STATEMENT, SINGLE CODE ONLY.

	2009	2009 BENCHMARK	2004
	%	%	%
Strongly agree	35	35	27
Tend to agree	39	40	40
Neither agree or disagree	11	11	7
Tend to disagree	7	7	16
Strongly disagree	4	4	8
Don't know[14]	2	2	N/A
None/ no opinion	1	1	2

BASE: ALL RESPONDENTS
Q16. **In terms of making your workplace a safer and more secure environment, what should be the priority for your organisation?** OPEN-ENDED. PROBE FULLY.

	%
Nothing/already safe/continue the good safety standards	20
Increased security/quicker response	14
Safety of staff/patients/public	10
Training/education for staff/conflict resolution/more security training for staff	8
Tracking staff/single worker safety	6
Security entry and restricted access	5
Install personal/security alarms/panic buttons/security devices	5
Enforce zero tolerance policy on verbal/physical abuse from	4

[12] In 2004 the question wording for types of abuse was asked separately: 'verbal abuse from the general public and patients, excluding verbal threats of physical violence'; and 'verbal threats of physical violence from the general public and patients'. The results have been re-based to calculate the combined percentages.
[13] 'Don't know' was not listed as a code in 2004
[14] 'Don't know' was not listed as a code in 2004

patients/families	
More support for staff	4
Staff availability	4
Better/closer/more secure car park	3
Improve external lighting	3
Make sure policies/procedures are in place/always adhered to	2
Public awareness on what's acceptable/signs/posters informing public abuse is not tolerated	2
More space/change the building	1
Install security screen at reception/pharmacy desk	1
Information on/shorter waiting times	1
More/better communication between team members	1
More information about who/where we are visiting/treating/problem patients	1
Provide mobile phones/provide phones with better coverage	1
Risk Assessments	1
Ensure patient confidentiality/conduct interviews in private rooms etc	*
Have a phone line/direct line to security/police/hotline to report incidents	*
Health and Safety – not specified further	*
Improve the waiting room area/make it more pleasant/more books/refreshments etc	*
Listen to staff	*
More resources/funding	*
More secure building/reception area (unspecified)	*
Prevent theft/better storage of equipment/valuables	*
Provide a high level of care/ensure patient care is not compromised	*
Other	7
Don't know	11

Q17. **At work, in the past 12 months, have you personally …?**
READ OUT LIST. MULTICODE OK

		2009 %	2009 BENCHMARK %	2004 %	
A1	Been verbally abused or verbally threatened by a patient	32	N/A	N/A	(Multi-code)
A2	Been verbally abused or verbally threatened by a member of the public (not a patient)	18	N/A	N/A	
B1	Been physically assaulted by a patient	5	N/A	N/A	
B2	Been physically assaulted by a member of the public (not a patient)	1	N/A	N/A	
	None of these[15]	63	63	54	(Single code)
	Don't know	*	*	*	

BASE: ALL RESPONDENTS WHO HAVE EXPERIENCED VERBAL ABUSE, OR HAVE BEEN VERBALLY THREATENED, BY A PATIENT IN THE PAST 12 MONTHS, 704

Q18 (A1). **In the past 12 months, how many times have you been verbally abused or verbally threatened by a patient?**
ENTER A NUMBER – NOT A RANGE. RESPONSES GROUPED FOR ANALYSIS.

	%	
Once	19	
2-5	44	
6-10	13	MEDIAN = 3.0
11-24	11	
25-49	4	
50+	9	

BASE: ALL RESPONDENTS WHO HAVE EXPERIENCED VERBAL ABUSE, OR HAVE BEEN VERBALLY THREATENED BY A MEMBER OF THE PUBLIC (NOT A PATIENT) IN THE PAST 12 MONTHS, 399

Q18 (A2). **In the past 12 months, how many times have you been verbally abused or verbally threatened by a member of the public (not a patient)?**
ENTER A NUMBER – NOT A RANGE. RESPONSES GROUPED FOR ANALYSIS.

	%	
Once	27	
2-5	38	
6-10	14	MEDIAN = 3.0
11-24	10	
25-49	4	
50+	7	

[15] It is only possible to benchmark single coded data at Q17 due to the revised question wording and the data available from the 2004 survey.

BASE: ALL RESPONDENTS WHO HAVE BEEN VERBALLY ABUSED OR VERBALLY THREATENED BY A PATIENT OR A MEMBER OF THE PUBLIC IN THE LAST 12 MONTHS.
2009 BASE: 810
2009 BENCHMARK BASE: 619
2004 BASE: N/A[16]

Q18 (A1/2). **In the past 12 months, how many times have you been verbally abused or verbally threatened by a patient/member of the public[17]**
ENTER A NUMBER – NOT A RANGE. RESPONSES GROUPED FOR ANALYSIS.

	2009	2009 BENCHMARK	2004
	%		%
Once	22	24	24
2-5	42	44	45
6-10	14	13	14
11-24	11	10	8
25-49	4	3	3
50+	8	7	6

BASE: ALL RESPONDENTS WHO HAVE EXPERIENCED PHYSICAL ASSAULT BY A PATIENT IN THE PAST 12 MONTHS, 113

Q18 (B1). **In the past 12 months, how many times have you been physically assaulted by a patient?**
ENTER A NUMBER – NOT A RANGE. RESPONSES GROUPED FOR ANALYSIS.

	%	
Once	50	
2-5	36	
6-10	10	MEDIAN = 2.0
11-24	4	
25-49	-	
50+	1	

BASE: ALL RESPONDENTS WHO HAVE EXPERIENCED PHYSICAL ASSAULT BY A MEMBER OF THE PUBLIC (NOT A PATIENT) IN THE PAST 12 MONTHS, 18

Q18 (B2). **In the past 12 months, how many times have you been physically assaulted by a member of the public (not a patient)?**
ENTER A NUMBER – NOT A RANGE. RESPONSES GROUPED FOR ANALYSIS.

	N	
Once	12	
2-5	3	
6-10	2	MEDIAN = 1.0
11-24	1	
25-49	-	
50+	-	

[16] It is not possible to determine the combined base size of Q18A1/A2 based on the data files available from the 2004 survey. The percentage results have been manually rebased and calculated from the archive data tables.
[17] In 2004 the question wording for types of abuse was asked separately, while in 2009 the question was asked separately of members of the public and patients. In both instances, the results have been re-based to calculate the combined percentages.

BASE: ALL RESPONDENTS WHO HAVE BEEN PHYSICALLY ASSAULTED BY A PATIENT OR A MEMBER OF THE PUBLIC IN THE LAST 12 MONTHS.
2009 BASE: 121
2009 BENCHMARK BASE: 80*
2004 BASE: 75*

Q18 (B1/2). **In the past 12 months, how many times have you been physically assaulted by a patient/member of the public**[18]
ENTER A NUMBER – NOT A RANGE. RESPONSES GROUPED FOR ANALYSIS.

	2009	2009 BENCHMARK	2004
	%	%	%
Once	53	52	67
2-5	34	30	27
6-10	10	14	3
11-24	10	3	4
25-49	-	-	-
50+	1	2	-
MEDIAN	1.0	1.0	1.0

* Note: small base size – treat with caution

BASE: ALL RESPONDENTS WHO SAY THEY HAVE EXPERIENCED A TYPE OF ABUSE IN THE LAST 12 MONTHS. VERBAL ABUSE OR THREATS (810) / PHYSICAL ASSAULT (121)

Q19. **Thinking about incidents involving** <IF CODED A1 OR A2 AT Q17 INSERT: **verbal abuse or threats** > OR <IF CODED B1 OR B2 AT Q17 INSERT: **physical assault**> **by members of the public or patients, do these usually occur ….**
READ OUT EACH SHIFT TYPE BELOW

		During the day/Day shift	**During the night/ Night shift**	**In equal measure day and night**	**DK/NA**
		%	%	%	%
A	Verbal abuse or threats	63	11	25	1
B	Physical assault	41	23	34	2

BASE: ALL RESPONDENTS WHO SAY THEY HAVE EXPERIENCED A TYPE OF ABUSE IN THE LAST 12 MONTHS, 820

Q20. **And what do you consider to be the main factors that have contributed to any verbal or physical abuse from members of the public or patients?**
DO NOT PROMPT. MULTICODE OK.

	%
As a consequence of the patient's mental health condition	19
The patient or member of public was under the influence of alcohol	19
The length of time waiting to be seen by a health professional	18
Problems understanding information and instructions	16
As a consequence of the patient's medical condition	10
Dissatisfaction with service/treatment/not getting what they want	9
Concern about their condition	8
The patient or member of public was under the influence of recreational drugs	8
Concern about another patient's condition	5

[18] In 2009, the question wording was asked separately of members of the public and patients: 'In the past 12 months, how many times have you been physically assaulted by a patient?'; and 'In the past 12 months, how many times have you been physically assaulted by a member of the public (not a patient)?' The results have been re-based to calculate the combined percentages.

The feeling that they should be prioritised over other patients	5
Frustration/anger	4
High/unreasonable expectations	4
Discomfort experienced in the waiting area	3
The patient or member of public was under the influence of prescription drugs/medication	3
Poor communication/communication breakdown	3
Their personality/attitude/bad manners/education	3
The length of time waiting to be seen by a receptionist	2
Anxiety/stress	2
Appointment issues/long wait/cancellations/not getting appointment they want	2
Car parking problems/lack of parking	2
Confusion	1
Funding/resources issues	1
Issues/concerns about child protection	1
Lack of information	1
Lack of staff	1
Patients are emotional	1
Problem with non-smoking policy	1
Restriction on visiting/opening hours	1
Waiting times	1
Bereavement of a family member	*
Bereavement of a friend	*
Intervention in an argument between two patients/members of the public	*
Intervention in an argument between a patient/member of the public and another NHS employee	*
Environment they are in	*
Influence by family/outside pressure	*
Staff issues (e.g. lack of training/attitude)	*

BASE: ALL RESPONDENTS WHO HAVE NOT EXPERIENCED ANY TYPE OF ABUSE IN THE LAST 12 MONTHS, 1,382

Q21. **At work, in the past 12 months, have you personally witnessed a colleague …?** READ OUT LIST. MULTICODE OK

		%
A	Being verbally abused or threatened with physical violence by a member of the public or a patient	22
B	Being physically assaulted by a member of the public or a patient	3
	None of these	77

Q22. REMOVED BEFORE THE START OF FIELDWORK.

BASE: ALL RESPONDENTS WHO HAVE BEEN VERBALLY ABUSED, THREATENED WITH PHYSICAL VIOLENCE OR PHYSICAL ASSAULT IN THE LAST 12 MONTHS.

Q23. **How have you personally been affected following incidents of <INSERT A> OR <INSERT B> from members of the public or patients?**
DO NOT PROMPT. MULTICODE OK.

	A) Verbal abuse or threats of physical violence (BASE: 810) %	B) Physical assaults (BASE: 121) %
It has not affected me	62	37
Experienced emotional and/or psychological distress	25	27
Feel less safe in the workplace	5	5
Experienced less job satisfaction/enjoyment	4	2
Feel less able to perform role	2	1
More negative attitude towards patients and public	2	-
Have taken time off work	1	5
Less trust/confidence in reporting procedure	1	3
Have learned more about personal safety - generally	1	2
Makes you more aware	1	-
More stress	1	2
Scared/worried	1	-
More positive attitude towards colleagues	*	-
More positive attitude towards patients and public	*	-
Less trust/confidence in NHS security	*	2
Have learned more about personal safety – through the NHS	*	7
Disrupted the working day	*	-
Learned to cope with it	*	-
Trouble sleeping	*	1
Upset	*	-
Suffered a short-term physical injury	-	17
Suffered a long-term physical injury	-	2
More negative attitude towards colleagues	-	1
Handed my notice/changed jobs	-	2
Other	2	1
Don't know	*	-

BASE: ALL RESPONDENTS WHO HAVE BEEN VERBALLY ABUSED, THREATENED WITH PHYSICAL VIOLENCE OR PHYSICAL ASSAULT IN THE LAST 12 MONTHS.

Q24. **Of the <INSERT NUMBER OF INCIDENTS FROM Q18> incidents of <INSERT: VERBAL ABUSE OR THREATS OF PHYSICAL VIOLENCE/PHYSICAL ASSAULTS> from members of the public or patients, how many have you reported?**
ENTER A NUMBER – NOT A RANGE. RESPONSES GROUPED FOR ANLAYSIS.

	A) Verbal abuse or threats of physical violence (BASE: 810) %	B) Physical assaults (BASE: 121) %
Zero	36	21
Once	22	43
2 to 5 times	26	27
6 to 10 times	7	2
11 to 24 times	4	3
25 to 49 times	1	-
50 or more times	3	1
Don't know	1	2

BASE: ALL RESPONDENTS WHO HAVE BEEN VERBALLY ABUSED, THREATENED WITH PHYSICAL VIOLENCE OR PHYSICAL ASSAULT IN THE LAST 12 MONTHS, 820

Q25. **Were any of these incidents reported to any of the following:**
READ OUT. MULTICODE OK FOR CODE A-D, SINGLE CODE ONLY FOR CODE E.

	%
A manager	65
Local Security Management Specialist (LSMS)	20
The Police	17
Consultant	*
Colleagues/staff	*
Doctor	*
Matron	*
Risk management/team/department	1
Incident form/risk events form	1
PCT	*
Senior manager	*
Security/guard/head of security	1
The GP/trust	*
Other specify	3
None reported	25

BASE: ALL RESPONDENTS WHO DID NOT REPORT EVERY INCIDENT OF VERBAL ABUSE OR THREAT OF PHYSICAL VIOLENCE IN THE LAST 12 MONTHS, 499

Q26 (A). **Why did you not report all incidents of (Verbal abuse or threats of physical violence) that you experienced?**
DO NOT READ LIST. PROMPT IF NECESSARY. MULTICODE OK.

	%
Used to it/part of the job	37
Situation was resolved/not serious enough	28
Time required to file a report	13
Sympathy for patient or a relative – patient was anxious/upset	11
Incident was as a result of the patient's clinical condition	11
Didn't think any action would be taken	10
Patient was under the influence of alcohol/drugs	3
Unaware of procedures	2
I am the person it would have been reported to	1
Fear of further violence	*
Did not want to get involved in court proceedings	*
Patient was disturbed/confused/under the influence	-
Other person reported it	-
Would have made the situation/Things worse	-
Incident is put on patient's file	-
Would depend on seriousness of incident	-
Concerned about being labelled as a troublemaker	-
Did not want to pursue for other reason	9
Don't know	6

BASE: ALL RESPONDENTS WHO DID NOT REPORT EVERY INCIDENT OF PHYSICAL ASSAULT IN THE LAST 12 MONTHS.
2009 BASE: 36
2009 BENCHMARK BASE: 21
2004 BASE: 22

Q26 **Why did you not report all incidents of (Physical assaults) that you experienced?**
(B). DO NOT READ LIST. PROMPT IF NECESSARY. MULTICODE OK.

	2009 N	2009 BENCHMARK N	2004 N
Patient was disturbed/confused/under the influence	-	-	10
Incident was as a result of the patient's clinical condition	10	6	-
Sympathy for patient or a relative – patient was anxious/upset	8	5	1
Situation was resolved/not serious enough	8	5	6
Used to it/part of the job	7	6	1
Didn't/Don't think any action would be taken	2	1	2
Unaware of procedures	2	-	-
Time required to file a report	2	-	3
Incident is put on patient's file	-		2
Patient was under the influence of alcohol/drugs	1	1	-
Concerned about being labelled as a troublemaker	-	-	-
Fear of further violence	-	-	-
Did not want to get involved in a court proceedings	-	-	-
Did not want to pursue for other reason	5	2	-
I am the person it would have been reported to	-	-	-

BASE: ALL RESPONDENTS
Q27. **How easy or difficult is it to complete an incident report form for <INSERT: VERBAL ABUSE OR THREATS OF PHYSICAL VIOLENCE/PHYSICAL ASSAULTS> from members of the public or patients? PLEASE ANSWER EVEN IF YOU HAVE NOT REPORTED AN INCIDENT.**
READ OUT. SINGLE CODE FOR EACH STATEMENT.

	A) Verbal abuse or threats of physical violence %	B) Physical assaults %
Very easy	41	40
Fairly easy	34	31
Neither easy nor difficult	5	4
Fairly difficult	7	7
Very difficult	3	2
No opinion	7	9
Don't know	5	7

2009 BASE: ALL RESPONDENTS
2009 BENCHMARK BASE: ALL RESPONDENTS
2004 BASE: ALL NHS HEALTH PROFESSIONALS WHO ARE NOT MANAGERS, 1,707
Q28 (A). **To what extent do you agree or disagree that (The NHS has an effective process to report incidents of verbal abuse, including threats of physical violence)?**
FOR EACH STATEMENT, SINGLE CODE ONLY. ROTATE STATEMENTS.

	2009	2009 BENCH MARK	2004
	%	%	%
Strongly agree	33	35	34
Tend to agree	40	41	36
Neither agree nor disagree	12	10	6
Tend to disagree	6	6	10
Strongly disagree	3	3	7
No opinion	5	4	7

2009 BASE: ALL RESPONDENTS
2009 BENCHMARK BASE: ALL RESPONDENTS
2004 BASE: ALL NHS HEALTH PROFESSIONALS WHO ARE NOT MANAGERS, 1,707
Q28 (B). **To what extent do you agree or disagree that (The NHS has an effective process to report incidents of physical abuse)?**
FOR EACH STATEMENT, SINGLE CODE ONLY. ROTATE STATEMENTS.

	2009	2009 BENCH MARK	2004
	%	%	%
Strongly agree	38	40	40
Tend to agree	40	41	37
Neither agree nor disagree	10	8	6
Tend to disagree	5	4	7
Strongly disagree	3	2	3
No opinion	6	4	7

2009 BASE: ALL RESPONDENTS
2009 BENCHMARK BASE: ALL RESPONDENTS
2004 BASE: ALL NHS HEALTH PROFESSIONALS WHO ARE NOT MANAGERS, 1,707
Q28 (C). **To what extent do you agree or disagree that (The NHS takes the appropriate actions to deal with reports of verbal abuse, including threats of physical violence)?**
FOR EACH STATEMENT, SINGLE CODE ONLY. ROTATE STATEMENTS.

	2009	2009 BENCH MARK	2004
	%	%	%
Strongly agree	27	29	22
Tend to agree	35	35	33
Neither agree nor disagree	15	14	9
Tend to disagree	10	10	13
Strongly disagree	5	5	9
No opinion	8	6	15

2009 BASE: ALL RESPONDENTS
2009 BENCHMARK BASE: ALL RESPONDENTS
2004 BASE: ALL NHS HEALTH PROFESSIONALS WHO ARE NOT MANAGERS, 1,707

Q28 (D). **To what extent do you agree or disagree that (The NHS takes the appropriate actions to deal with reports of physical abuse)?**
FOR EACH STATEMENT, SINGLE CODE ONLY. ROTATE STATEMENTS.

	%
Strongly agree	30
Tend to agree	35
Neither agree nor disagree	15
Tend to disagree	7
Strongly disagree	4
No opinion	8

BASE: ALL RESPONDENTS

Q28 (E). **To what extent do you agree or disagree that the (Reporting an incident of physical or verbal abuse leads to a satisfactory outcome)**
FOR EACH STATEMENT, SINGLE CODE ONLY. ROTATE STATEMENTS.

	%
Strongly agree	16
Tend to agree	31
Neither agree nor disagree	22
Tend to disagree	11
Strongly disagree	7
No opinion	12

BASE: ALL WHO DISAGREE THAT REPORTING AN INCIDENT OF PHYSICAL ABUSE LEADS TO A SATISFACTORY OUTCOME, 403

Q29. **You disagree that reporting an incident of physical or verbal leads to a satisfactory outcome. Why is this?** DO NOT READ OUT. MULTICODE

	%
Insufficient penalties for offender	21
Inadequate communication from manager	20
Nothing gets done – not specified further	16
No feedback/lack of feedback/haven't heard anything back	10
Not followed up properly	9
No written correspondence from LSMS	6
No contact from police (if reported to police)	6
No phone call or email from LSMS	5
Nothing can be done/there are more rights for patients than for staff/mental health patients are not made responsible for their actions	5
Time consuming/lengthy/complex/slow process	5
Insufficient measures/procedures in place	4
No support for victims/not a supportive system	4
Staff/Society accepts/expects the abuse/part of the job	3
Incident will happen again/it continues/can't change people	2
Management/authority doesn't respond/sweeps it under the carpet	2
Personal experience/general feeling I have	2

From what I have heard from other staff	1
I am not aware of procedures/steps available	1
It is down to the individual to do something	1
People don't report it/reluctant to report it	1
Other	5
Don't know	2
No answer	1

SCREENING QUESTIONS

BASE: ALL RESPONDENTS.
DO NOT READ OUT. **Gender.**
SINGLE CODE ONLY.

	2009	2009 BENCH MARK	2004
	%	%	%
Male	28	20	28
Female	72	80	72

Role. **DO NOT ASK – MANAGE AT SAMPLE LEVEL. SINGLE CODE ONLY.**

	2009	2009 BENCH MARK	2004
	%	%	%
Doctor – A&E (NEED 50)	2	2	3
Doctor – GUM (NEED 50)	2	3	3
Doctor – older adults (NEED 50)	2	2	3
Doctor – psychiatrist (NEED 50)	2	3	3
Doctor – ob/gyn (NEED 50)	2	2	3
Doctor – other (NEED 100)	5	4	6
Midwives (NEED 100)	5	6	6
Hospital/ Inpatient nurse (NEED 200)	9	12	12
Practice nurses (NEED 100)	5	6	6
Community nurse (NEED 100)	5	6	6
Community psychiatric nurses (NEED 100)	5	6	6
Practice managers (NEED 100)	5	6	6
District nurses (NEED 100)	5	6	6
Administrative staff (NEED 100)	5	6	6
Reception/ Ward clerk (NEED 100)	5	6	6
Health visitor (NEED 100)	5	6	6
Pharmacist (NEED 100)	5	6	6
Complaints/ PALS staff (NEED 100)	5	6	6
Manager / Senior manager (NEED 100)	5	6	6
A&E nurse (NEED 100)	5	N/A	N/A
Porter (NEED 50)	2	N/A	N/A
Security staff (NEED 50)	2	N/A	N/A
Allied health professionals (NEED 50)	2	N/A	N/A
Dentists (NEED 100)	5	N/A	N/A
Opticians (NEED 100)	5	N/A	N/A

What was your age on your last birthday?

	2009	2009 BENCH MARK	2004
	%	%	%
16-24	3	1	*
25-34	19	14	15
35-44	27	28	33
45-54	33	36	35
55-59	11	13	12
60-64	5	6	3
65-74	1	1	1
75+	*	*	*
Refused	-	-	1

WORKING STATUS OF RESPONDENT.
And how many hours a week do you work?
SINGLE CODE ONLY.

	2009	2009 BENCH MARK	2004
	%	%	%
Working - Full time (30+ hrs)	82	79	80
- Part-time (9-29 hrs)	18	21	20
Other	*	*	*

BASE: ALL HOSPITAL OR A&E NURSES (CODED 8 or 20), 300
And what is your current staff grade?
SINGLE CODE ONLY.

	2009	2009 BENCH MARK	2004
	%	%	%
Qualified nurse (but not staff) nurse)	15	17	14
Staff nurse	31	34	29
Charge nurse	7	10	15
Sister/nurse consultant or manager or above	29	25	34
Not specified	1	1	1
Matron	N/A	N/A	1
Midwife	N/A	N/A	1
Other	11	13	4
Missing	6	-	-

BASE: ALL DOCTORS[19] (CODES 1, 2, 3, 4, 5 and 6), 351
And what is you current staff grade?
SINGLE CODE ONLY.

	2009	2009 BENCH MARK	2004
	%	%	%
Consultant	32	44	39
In training (F1/F2)	6	1	N/A
StRs (FTSTAs/LATs)	10	5	N/A
SHOs	7	2	N/A
SpRs/SpTs/GPRs	15	14	N/A
Staff and Associate Specialists	17	22	N/A
Non-consultant career grade	2	1	N/A
Not specified	2	2	-
House Officer	N/A	N/A	-
Senior House Officer	N/A	N/A	18
Specialist Register	N/A	N/A	10
Staff grade	N/A	N/A	22
Associate specialist	N/A	N/A	6
Professor/Senior Lecturer	N/A	N/A	1
Other	10	8	5

BASE: ALL WILLING TO ANSWER, 1914
QB. **Do you have any long-standing illness, disability or infirmity? By long-standing I mean anything that has troubled you over a period of time or that is likely to affect you over a period of time?**
READ OUT. SINGLE CODE ONLY.

	%
Yes	9
No	91

BASE: ALL WILLING TO ANSWER, 1968
QC. **To which of these ethnic groups would you say you belong?** SINGLE CODE ONLY.

	2009	2009 BENCH MARK	2004
	%	%	%
White:			
British	79	82	77
Irish	2	2	3
Any other white background	4	2	3
Mixed:			
White and Black	*	*	*
White and Black Caribbean	-	*	*
White and Black African	-	*	*
White and Asian	*	*	1
Any other mixed background	1	1	1
Asian or Asian British:			
Indian	6	4	5
Pakistani	1	1	2
Bangladeshi	*	*	*
Any other Asian background	2	2	2
Black or Black British:			

[19] Please note the changes to Doctor/GP classifications since 2004.

Caribbean	1	1	2
African	2	2	2
Any other Black background (WRITE IN AND CODE)	*	*	*
Chinese or other ethnic groups:			
Chinese	1	*	1
Any other ethnic group	1	1	2
Don't know	-	-	1
Refused	*	*	1

BASE: ALL WILLING TO ANSWER, 1912
QD. **What is your religion/belief?** DO NOT READ OUT. SINGLE CODE ONLY.

	%
No religion	26
Bahai	*
Buddhist	1
Christian (incl. Church of England/ Scotland, Protestant, Catholic and any other Christian denomination)	62
Hindu (Hindi)	4
Jain	*
Jewish (Judaism)	*
Muslim (Islam)	3
Sikh	1
Other (PLEASE WRITE IN)	2
Refused	*

BASE: ALL WILLING TO ANSWER, 1868
QE. **Can you tell me, are you … ?** READ OUT A-D. SINGLE CODE ONLY

		%
A	Bisexual	1
B	Gay man/homosexual	1
C	Gay woman/lesbian	*
D	Heterosexual/straight	97
	Prefer not to say	1

Guide to Statistical Reliability

Because a sample, rather than the entire population, was interviewed the percentage results are subject to sampling tolerances – which vary with the size of the sample and the percentage figure concerned. For example, for a question where 50% of the people in a (weighted) sample of 2,202 respond with a particular answer, the chances are 95 in 100 that this result would not vary more than two percentage points, plus or minus, from the result that would have been obtained from a census of the entire population (using the same procedures). An indication of approximate sampling tolerances is given in the table below.

Size of sample on which the survey results are based	**Approximate sampling tolerances applicable to percentages at or near these levels**		
	10% or 90%	**30% or 70%**	**50%**
	±	±	±
2,202 interviews	1	2	2

For example, as shown in the table above, with a sample of 2,202 where 30% give a particular answer, the chances are 19 in 20 that the "true" value (which would have been obtained if the whole population had been interviewed) will fall within the range of plus or minus two percentage points from the sample result.

Strictly speaking, the tolerances shown here apply only to random samples; in practice good quality quota sampling has been found to be as accurate.

When results are compared between separate groups within a sample, different results may be obtained. The difference may be "real", or it may occur by chance (because not everyone in the population has been interviewed). To test if the difference is a real one - i.e. if it is "statistically significant", we again have to know the size of the samples, the percentage giving a certain answer and the degree of confidence chosen. If we assume the "95% confidence interval", the differences between the two sample results must be greater than the values given in the table below:

Size of samples compared	**Differences required for significance at or near these percentage levels**		
	10% or 90% ±	*30% or 70%* ±	*50%* ±
2,202 and 610 (All respondents vs. men)	3	4	5
1,796 and 402 (respondents working full-time vs. respondents working part-time)	3	5	5
520 and 829 (respondents who have attended CRT in the last 12 months vs. respondents who have never attended CRT)	3	5	6