Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Archwilio
The Audit Committee

Dydd Mercher, 25 Mawrth 2009
Wednesday, 25 March 2009

Cynnwys
Contents

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

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

Aelodau Cynulliad yn bresennol
Assembly Members in attendance

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

Eraill yn bresennol
Others in attendance

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

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

John Grimes	Clerc Clerk
Abigail Phillips	Dirprwy Glerc Deputy Clerk

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

Ymddiheuriadau a Dirprwyon
Apologies and Substitutions

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

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

9.31 a.m.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9.40 a.m.

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

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

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

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

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

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

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

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

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

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

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

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

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

9.50 a.m.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10.00 a.m.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10.10 a.m.

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

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

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

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

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

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

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

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

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

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

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

I am not aware of any study or work.

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

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

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

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

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

10.20 a.m.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10.30 a.m.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10.40 a.m.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10.50 a.m.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11.00 a.m.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11.10 a.m.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11.20 a.m.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11.30 a.m.

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

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

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

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

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

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

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

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

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

taken seriously.

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

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

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

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

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

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

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

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

11.37 a.m.

Cynnig Trefniadol
Procedural Motion

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

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

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

Derbyniwyd y cynnig.
Motion agreed.

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