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# NHS violence prevention and reduction standard

## Guidance notes

13 June 2022

# Contents

# 1. Overview

This guidance document is designed to be used in conjunction with the NHS violence prevention and reduction (VPR) standard. We want to help provider organisations share and communicate risks of violence and their mitigation controls through processes that are robust and transparent.

This guidance will help the implementation of a data-driven method focusing on colleague health and wellbeing, in a way that is reflective, proactive, preventative, responsible and accountable.

By working through the VPR Standard and this guidance, you will be able to test and measure performance against your overall violence prevention and reduction strategy. This will be a key step towards implementing a commitment to colleague health and wellbeing through the adoption of public health methods.

The NHS Long Term Plan and the NHS People Promise both demonstrate a commitment to the health and wellbeing of NHS colleagues, recognising the negative impact that poor staff health and wellbeing can have on patient care. Violence toward NHS colleagues is one of the many variables that can have a devastating and lasting impact on health and wellbeing. Therefore, a fundamental part of our partnership work around health and wellbeing is focused on the prevention and reduction of violence toward NHS colleagues.

All providers of NHS-funded services operating under the NHS Standard Contract are required to review their status against the VPR Standard, providing board level assurance that the Standard has been achieved at a minimum of six-monthly intervals. Commissioners are expected to undertake compliance assessments as part of their regular contract reviews twice a year as a minimum, or quarterly if significant concerns are identified and raised.

The VPR Standard will be reviewed annually or following significant changes, ie because of relevant legislative and/or strategic changes. The VPR Standard has been developed with partners from the Social Partnership Forum (SPF) and its subgroups, the Workforce Issues Group and the Violence Prevention and Reduction Group. The VPR Standard is managed by NHS England and NHS Improvement and was endorsed by the SPF in December 2020.

A summary of the relevant legislation on an employer's general duty of care to protect staff can be found at annex 1.

# 2. Approach

The NHS VPR Standard employs the Plan, Do, Check, Act (PDCA) approach, also known as the Deming Wheel or Deming Cycle (see also Plan Do Study Act [PDSA]). It is an iterative four-step management method to validate, control and achieve continuous improvement of processes.

When self-assessing against the Standard, bear in mind it is a risk framework, not a compliance tool. It should be considered one Standard, made up of multiple indicators. The Standard is considered achieved only once all indicators have been met and fully evidenced; and each indicator is absolute, in that a provider organisation either meets it fully, or does not meet it. There should be no partial meeting of indicators as this gives a false impression of the organisation's current position. Where an indicator is not fully met, we would advise your organisation to embrace, accepting that change is not an immediate process.

We recommend that the initial assessment against the Standard is co-produced by the violence prevention and reduction lead, or the individual with responsibility for violence prevention within the provider organisation. As a minimum, this co-production should involve both executive and senior management level collaboration, and this level of leadership and engagement should be maintained throughout the development and implementation of the VPR programme.

Key internal and external stakeholders should be invited to contribute to the initial and subsequent assessments and reviews of the provider organisation's violence prevention and reduction programme against the VPR Standard.

Evidence for where the criteria or indicators have been met should be recorded and articulated. Working through the framework, and once fully completed, the VPR Standard should be shared with relevant and wider stakeholders for further discussion, consideration, and input.

Findings should be shared with executive level senior management and leadership teams to determine and agree next steps. Any concerns or risks highlighted should be addressed here.

Where best practice examples are evidenced, these should be promoted. Interventions, solutions, and control measures that work well in one area can invariably be replicated in others with localised adaptation. You may want to reflect on how you can promote and share good practice examples within the wider remit of integrated care systems (ICSs).

Following self-assessment against the VPR Standard, you should develop a clear plan, with defined roles and responsibilities, for the discharge of any actions identified. Actions may include, but are not limited to, further investigation, validating and evidence gathering against the VPR Standard or indicators within the framework. We also advise that any actions and risks identified should be included as part of your wider risk assessment and risk management processes and plans.

Fundamental to the whole approach and underpinning the philosophy and ethos of violence prevention and reduction, is the science and methodology of public health. Further details on how this approach works within the field of violence prevention and reduction can be found here: A whole-system multi-agency approach to serious violence prevention (publishing.service.gov.uk).

# 3. PDCA – Plan

At the planning stage of self-assessment against the VPR Standard, general considerations you may wish to reflect on include:

- Think about where you are now and where you want to be.
- Develop your aim(s) – say what you want to achieve, who will be responsible for what, how you will achieve your aims, and how you will measure your success.
- Decide how you will measure the organisation's performance against the Standard. Consider options that go beyond looking solely at reported incident figures.
- Examples of quantitative and qualitative data could include:

**Quantitative data**

- staff sickness rates
- injury rates
- recruitment and retention data
- staff survey data
- complaint data
- trends in incidents

**Qualitative data**

- incident reports
- nature and content of complaints and compliments
- exit interview data
- 15 Steps Challenge/First impressions data
- general 'soft' intelligence, generated through informal conversations

- Co-operate with partners and key stakeholders and co-ordinate plans with them.
- Remember to plan for changes and identify any specific legal requirements that apply to you.
- Plan for learning from the beginning of the process. This will promote the flow of learning through the whole PDCA cycle. Planning for learning from the outset will promote creativity and promote an 'organisation with a memory'. Please see: An Organisation with a Memory: Report of an Expert Group on Learning from Adverse Events in the NHS Chaired by the Chief Medical Officer. | PSNet (ahrq.gov)

To assist with the planning process, several specific key indicators have been produced that provider organisations need to consider, explored in detail here. This section covers three key points:

- Board and executive level responsibility and accountability.
- The development of a violence prevention and reduction strategy and policy supported by specific VPR plans.
- The development of performance measures to demonstrate delivery against the organisation's strategy and the VPR Standard.

## Key indicators

### 3.1 The board (non-exec and exec members) endorses the violence prevention and reduction policy

#### 3.1.1 Has the organisation developed their violence prevention and reduction strategy?

- Does this provide a detailed and realistic plan of action and a commitment to preventing and reducing violence?
- Does the strategy reflect current best practice; is it underpinned by the evidence base?
- Does it reflect a commitment to adopting a public health approach to violence prevention and reduction?
- Is the strategy supported by the science of public health?
- Does the strategy incorporate an evidenced based method – eg a trauma informed approach, or the See-Think-Act framework?
- Is the strategy reflective of the current legislation in the area?
- Is the strategy reflective of any clinical guidelines from NHS England and NHS Improvement, Department of Health and Social Care, other governmental departments or the National Institute for Health and Clinical Excellence?

### 3.1.2 Engagement

Who have you engaged with in developing your VPR strategy? For example:

- patient/carer/relative groups
- third sector organisations
- social services
- police
- staff side representatives
- medical
- nursing
- allied health profession (AHP) representatives
- health and safety representatives
- commissioners
- CQC
- NHS England and NHS Improvement
- ICS
- other NHS partners in the community
- local authority partner(s)
- local community groups
- the local violence reduction unit.

### 3.1.3 Risk assessment

- Is the strategy reflective of the current situation in the organisation – think data, risk assessments, training needs analysis.
- Have you shared these risks with your key stakeholders and partners including the ICS?
- Is the organisation open and transparent about its current risks, and how is this demonstrated?

### 3.1.4 Has the organisation developed its violence prevention and reduction policy?

- Is this reflective of the strategy?
- Does it adhere to the same principles of development as the strategy – eg.:
  - evidenced-based
  - public health underpinned
  - data driven
  - reflective and demonstrative of engagement with key stakeholders and partners.
- Is it supported by workforce and workplace risk assessments with a sound risk management approach?

### 3.1.5 Protected characteristics

- How does the violence prevention and reduction strategy and policy impact on those with protected characteristics?
- Is this reflected in the equality impact assessment?
- Are trends for violence and aggression against groups with protected characteristics being monitored and addressed?
- Who are the key stakeholders and groups that you need to consult with about any trends/themes involving those with protected characteristics?

### 3.1.6 Accountability

- Who is responsible for the development of the violence prevention and reduction strategy and policy?
- Who at board level will be responsible for the strategy and policy?
- Who at board level will be accountable for the strategy and policy?
- Is there a named person(s) for responsibility and accountability – what are their experiences, skills, and knowledge – is this just an 'add-on' to someone's existing role(s)?
- Think how will that person be responsible and accountable – how engaged are they with the problem of violence in the organisation?
- How committed are they to solving the problem of violence in the organisation?
- Does the board fully understand what they are endorsing when they endorse the violence prevention and reduction strategy and policy?
- If there is no named person(s) responsible and accountable, what is the rationale for this approach?

## 3.2 Objectives and performance criteria are clearly defined

### 3.2.1 **What is the overall aim of your organisation's violence prevention and reduction strategy?**

How will this be achieved? Start to plan how you will achieve your aim through clearly identified objectives – these objectives should be realistic and easily defined and identify the key stakeholders/people who will be required to achieve and meet your objectives.

### 3.2.2 Performance criteria

- What are your performance outcomes?
- Do these accurately reflect your violence prevention and reduction strategy?
- How will you measure your performance?
- What are the potential weaknesses in your performance criteria?
- Are your performance criteria and outcomes SMART?
- Could your performance criteria result in unintended consequences?
- Are your performance criteria a true reflection of your performance?
- Are you relying on quantitative measures solely or adopting a blended mixed method approach?
- How reliable is your performance data?

## 3.3 Violence prevention and reduction plans are recorded, implemented, and maintained

### 3.3.1 Overall strategy

As part of your overall strategy and policy in violence prevention and reduction, after developing your aim(s) and objectives there will be a requirement to design and develop specific plans that will outline how you as an organisation intend to meet your objectives and overall aim(s).

You will need to consider who your key stakeholders will be for this process. This may depend on the aim(s) and objectives you are trying to achieve. Different people may be responsible for specific plans and they should have input into the development of these plans.

### 3.3.2 Violence prevention and reduction plans

Plans should be subject to testing, validation and review to ensure that they are helping you and the organisation meet the specific goals and objectives that have been set in the violence prevention and reduction strategy and policy.

These plans should also be informed by new and emerging data, for example from incident reporting, trend and theme analysis, incident reviews, complaints, compliments and risk assessment(s). Remember

to share good practice across the organisation and with other organisations, for example through the ICS, so that good practice becomes the norm rather than the exception.

**3.3.3 Rather than rolling out your plans wholescale, consider developing small pilot test sites that will enable you to see what does and doesn't work**

Consider using a simple strategy for developing and delivering your plans, for example adopting the quality improvement framework Plan-Do-Study-Act (PDSA) (Layout 1 (england.nhs.uk).

**3.3.4 Things to remember at this point:**

- What are we trying to accomplish? (The strategy, aims and objectives statement)
- How will we know if the change is an improvement? What measures of success will we use? (Objectives and performance criteria)
- What changes can we make that will result in improvement? (Violence reduction and prevention plans)
- Who is accountable and responsible for violence prevention and reduction in the organisation?
- Who is accountable and responsible for violence prevention and reduction in our partners and key stakeholder's organisation(s)?
- Are we engaging with the right people in developing our strategy and policy?
- What is our holistic view of the data – what is it telling you?
- What about those with protected characteristics?
- How are we going to act on what we now know?

# 4. PDCA – Do

Once the planning stage of the cycle has been completed, providers will move through to the second stage, 'Do'. This stage is concerned with ensuring you have in place robust and transparent processes and practices for sharing and communicating violence risks along with their mitigation controls.

All forms of communication should be considered in the dissemination and distribution of information in a readily available and easily accessible form. Assurances should also be in place to measure and evaluate the effectiveness of the communication tools used to ensure all staff groups and key stakeholders are regularly engaged and informed.

When working through this stage, providers should consider three key principles:

- The how and why, to the assessment and management of risks.
- Ensuring processes that are implemented to achieve the key elements of the VPR standard are communicated and involve NHS staff and key stakeholders in their delivery.
- The provision of adequate resources and training needed to meet the VPR standard.

To aid you in achieving these principles, four key indicators can be used, explored in greater detail below.

## 4.1 Board members approve resources

Questions and points to consider here:

- Can you evidence how senior management assesses and manages risks pertaining to preventing and reducing violence and abuse towards staff?
- What practices, processes and policies are in place that enables data-led and evidence-based decision making?
- Can you provide robust and reliable evidence (both qualitative and quantitative) and data on the scale of the problem of violence in the organisation?
- Dependent on the scale of the problem, do you have adequate resources to address the problem?
  - If not, how will this be addressed?
  - What immediate and remedial interventions and plan(s) can be developed that redress this?
- How are lines of responsibility framed and viewed both internally and externally: are there designated operational, strategic, and executive leads?
  - Who do they report to and do they have the authority to make decisions, allocate resources and manage risks to keep staff safe?

- Do staff and stakeholders know who they are and how to access them to raise and share concerns?
  - How is this communicated throughout the organisation and where is it recorded, ensuring actions and decisions are logged?
  - Can the provider demonstrate that the information is easily accessible and available?

## 4.2 Regular workforce engagement

This section examines how diversity across the organisation should be accounted for, with regards to communications and engagement. Attention should be given to the value, place and purpose of equality impact assessments and public sector equality duty to consider how policies, practices and decisions affect staff, and those protected under the Equality Act 2010.

Consider how you or the provider engage with the workforce: can you show where, how and when the senior management team provides communication on the violence prevention and reduction objectives and priorities; and is this information readily available and easily accessible?

Questions and points to consider:

- Can the provider organisation demonstrate that its communications reach and cover all staff groups and functions internally?
  - Is there a process or mechanism to check how effective the communication methods are?
  - How confident are you and the provider organisation that diverse and under-represented groups are included?
- What about engagement with external stakeholders?
  - Is it demonstrable that trade unions and other workforce groups and stakeholders are consulted and engaged in tackling the issue of violence prevention and reduction?
  - Is this engagement ad-hoc or formal with regular timed reviews?

## 4.3 Clear roles, responsibilities and training

There is a need for clear lines of accountability and transparency of potential risks through resources and investment required to redress any skills or training needs

identified. Gaps or shortages should be reflected within your organisation's risk management policies and plan of action.

Consider the lines of sight between roles, responsibilities and training. For example, can you demonstrate that roles and responsibilities pertaining to violence prevention and reduction are clearly set out in any policy documentation? How and where is this documented? From a training perspective, what evidence is there to demonstrate that a training needs analysis (TNA) – pertaining to violence prevention and reduction and informed by any risk assessments as relates to violence and abuse towards staff – has been undertaken?

Points to consider:

- As a result of the TNA, has suitable and relevant training, development and support been made available and provided to staff?
- Consider how you can demonstrate that any training intervention is fit for purpose and effective – how is any training intervention evaluated?
- What is the process for evaluation of training interventions?
  - Is the process for training evaluation structured, systematic and evidence-based? (see Evidence-Based Evaluation Resources & Tools - OOMPH Library Resources: PHW 218 Evaluation of Health and Social Programs - Library Guides at UC Berkeley)
- What about the availability of the TNA?
  - How and where is this available to staff, senior management and stakeholders to review?
  - Is the information documented and are there actions as a result of any skills or training gaps?
  - If so, who is accountable and responsible and is there a plan of action by when deficiencies will be redressed?

## 4.4 Regular risk assessment

The fourth indicator relates to the assessment of risk and the processes and practices behind this. Consider whether you can demonstrate that policies and practices are in place, pertaining to the regular risk management and assessment of violence prevention and reduction against staff.

Points to consider:

- How is this information captured and where is this documented?
- How are risks communicated across the organisation and with key stakeholders?
- How easily can staff and stakeholders assess this information?
- What plans are in place to mitigate and reduce risks to staff?
- Where is accountability held for the progression and actioning of plans and responsibilities?
- How frequently is the information shared and reviewed?

# 5. PDCA – Check

What your organisation needs to consider at the 'Check' stage is how successful any implemented interventions have been; for example, have risks been controlled adequately, have the aim(s) of the violence prevention and reduction strategy been achieved. Testing interventions, perhaps via the PDSA cycle (Layout 1 (england.nhs.uk)) or through a measure such as an audit tool, or a Strengths Weaknesses Opportunities Threats (SWOT) appraisal, can assist with this stage.

Potential weaknesses and gaps in provision can be routinely assessed here, enabling swift corrective action, while areas of good practice can be identified and further spread throughout the provider organisation. To assist with this process, the use of both qualitative and quantitative data will assist in establishing trends of violence, including areas where this has fallen, risen, or remained static.

Adopting an epidemiological approach to violence prevention and reduction will ensure that all data that is generated within an organisation can be used to track trends and ultimately work toward supporting colleagues. Good governance, through assurance pathways is key to underpinning this work, as is adopting and promoting a transparent approach to risk management that responds to live data in a reflective but proactive fashion.

Overall, this stage of the cycle is concerned with testing the performance of your organisation's violence reduction and prevention programme and its resilience to system strain through key indicators based around good governance procedures and processes. Four key indicators have been developed to assist you in successfully navigating the Check stage of the VPR standard cycle, explored further below:

## 5.1 Process to assess violence prevention and reduction performance

These structures should reflect the VPR strategy and include mechanisms for the continual monitoring of the developed VPR plans. While the framework of governance is structured, there needs to be a degree of flexibility so that your organisation can respond appropriately and swiftly to serious incidents. Multiple strands of evidence could be used here, such as the provider organisation's VPR policy, incident review group meeting minutes, and senior management group meeting minutes.

Points to consider:

- Consider your organisation's culture of reporting and recording of incidents of violence: does it value the reporting process and promote this message to all colleagues in a positive way?
- Is your organisation encouraging a positive reporting culture, such as using continual campaigns, staff bulletins, the monitoring of incident reporting trends and themes?
- Has your organisation considered, for example, that a communications and education package for supervisors would help promote a positive reporting culture?
- Rather than the number of incidents of violence increasing being solely just a cause for concern, an increase in reporting – particularly after promotion of a positive reporting culture – could be evidence of good practice and an achievement toward a positive reporting culture.

Essentially, what an organisation should be attempting to achieve here is that effective monitoring of VPR systems is in place and that this is built into the fabric of the organisation's existing governance structures, including timescales for review. Good governance will assist the promotion of a positive reporting culture.

## 5.2 Data is traceable, retrievable, and accessible

An integral part of good governance and an underpinning structure of the science behind public health is the management and analysis of data, both qualitative and quantitative. As with the multiple strands of data that all provider organisations within the NHS handle, your organisation should manage all violence data in accordance with the General Data Protection Regulations (GDPR), which in turn should be governed by your organisation's information governance (IG) policies and procedures. An integral element of violence prevention and reduction is the sharing of data both internally and externally with partner agencies. Do you have in place an information/data sharing agreement with external agencies and stakeholders, supported by an appropriate legally structured policy and procedural document(s)?

Epidemiology is an underpinning foundation of the overall public health approach to VPR and is reliant on easily accessible, retrievable, and traceable data sources. As such, your organisation should be able to establish and evidence how violence data is frequently analysed using primary metrics to support violence prevention and

reduction assessments and interventions, using this data to inform the testing and audit processes underpinning any prevention and reduction interventions and initiatives.

Trend analysis of all sources of data will enable the provider organisation to identify areas with high prevalence of violence while opening other avenues for discussion, reflection, and further analytical testing. Consider analysing data using broad metrics, including workforce demographic(s) such as age, sex, ethnicity, disability, and sexual orientation.

Points to consider:

- Through data analysis, are you or the provider organisation able to identify which colleague groups are at most risk of discrimination?
- Is your organisation able to identify colleagues who are being targeted because of their protected characteristics?
- Can your organisation evidence how specific support is being implemented to those colleague groups, including those with protected characteristics, who have been identified through data analysis as being at increased risk of violence?
- Can your organisation evidence that the data analysis process is thorough, accurate, meaningful and deconstructs the root cause(s) of violent incidents?
- From a governance perspective, how is this data analysis reported and acted on?
- Is your organisation's senior management/executive team able to respond adequately to reduce incidents of violence in specific areas/against specific colleague(s) based on the data presented, particularly in areas with high prevalence of violence?

In summary, can your organisation demonstrate that violence data is:

- secure
- access controlled
- used effectively with other stakeholders to minimise risk and identify threats

- nimble enough to respond to live intelligence, particularly where high levels of prevalence in specific areas or against specific colleague groups is identified?

## 5.3 Established audit and assurance process for violence prevention and reduction

What processes are evident within your organisation for appraising and reviewing violence prevention and reduction performance, ensuring that all associated systems and practices are effectively managed and assessed regularly? For example, this process could be part of the day-to-day management of incidents recorded via a trust's incident reporting system, linked directly (where possible) to a provider's risk management system, ensuring that identified risks are updated and evidenced with live data and intelligence.

Part of the appraisal and review process should include review by your organisation's senior management team/executive level team twice yearly as a minimum. The review should be informed by any relevant data, for example audit data, project data, testing data.

Ultimately, this section reflects the requirement for effective governance around violence prevention and reduction processes, and poses the following outcome question: can the provider organisation demonstrate effective quality assurance across their violence prevention and reduction system(s)?

Points to consider:

- How can you or the organisation demonstrate assurance around the processes that have been developed for violence prevention and reduction?
- Does the data collected about violence provide assurances that the processes in place developed for violence prevention and reduction are effective?
- Is the provider organisation able to evidence and identify where lessons can be learnt and that policy objectives are being achieved?
- How responsive is your organisation to shifting trends via data analysis? For example, are policies, procedures and practices reviewed and updated in a timely fashion based on trend data analysis?

## 5.4 Process for corrective and preventative actions for violence prevention and reduction

Learning lessons from the data that provider organisations collect and analyse on violence is a critical strand of the public health approach to violence prevention and reduction. A process of post-incident management should see all logged violent incidents reviewed and assessed, with corrective actions and future interventions recorded within acceptable timeframes. Supporting colleagues through regular feedback of all reported incidents is a critical demonstration of your organisation's commitment to health and wellbeing.

Points to consider:

- How does your organisation validate its commitment to colleague health and wellbeing, both before and after violent incidents?
- How is this recorded and communicated to senior management, colleagues and stakeholders?
- What about feedback loop provision?
  - How are colleagues regularly kept 'in the loop' about violence and violent incidents?
  - What about where this may be prolonged by investigations?
- What does 'staff support' look and feel like across the organisation and externally with stakeholders?
- How is the provider's commitment to colleague health and wellbeing reflected in a commitment to the NHS staff charter, or the code of practice for victims of crime in England and Wales?
- How consistent is your organisation's approach to all reported incidents? Is there a systematic, structured and scientific approach to this? (eg Violence Prevention Alliance Approach [who.int]) Or is this approached through the application of key investigative standards? (Managing investigations [college.police.uk])
- Is this reflected in appropriate and relevant policies and processes? If so, how will your organisation establish the effectiveness of these policies and process for corrective and preventative interventions?
- How do you collate the collected data?
- What type of coding system is your organisation using?
- How is this aligned with outcomes and key performance indicators (KPIs):

  - internally (e.g. within the violence prevention and reduction strategy)
  - externally? (e.g. using metrics such as the Home Office crime outcomes framework – Crime outcomes in England and Wales 2020 to 2021 - GOV.UK [www.gov.uk])
- Consider shared data with key stakeholders; what does this tell you about what is happening on a micro-environment level? For example, local crime data, public health profiles, VRU data, local authority data.
- Where risks are generated through analysis of the data, how are they identified and subsequently managed? Where is this reported and recorded organisationally?
- How is current data fed into that system so that the violence risk management system is updated accordingly? Is this reflected in the organisation's violence risk management register?
- How is data generated ad-hoc following incidents inputted into the violence risk management system and linked to individual risks?
- How is the violence risk management system audited? Where does responsibility and accountability sit for the violence risk management system?

When reflecting on this, consider if responsibility and accountability is set at a suitable level for the inclusion or assessment of risks and how you or the provider organisation scrutinises these processes, perhaps through a peer review process (Peer review training (rcpsych.ac.uk) stakeholder appraisal, or internal mechanisms such as board governance.

# 6. PDCA – Act

There is a requirement for provider organisations to reflect and appraise their overall performance, using the senior management team as a conduit to direct and inform changes to policies or plans, in response to trend analysis of the violence data. Transparency and the sharing of information are key to this approach, with internal and external stakeholders being fundamental partners.

This section is concerned with testing and measuring the provider organisations performance against their overall violence prevention and reduction strategy. The key indicators within the 'Act' section are designed to encourage executive level

and senior management level engagement and oversight in the review of the providers performance against the VPR Standard.

This section is not only concerned with identifying deficits in performance, but just as importantly, is concerned with identifying areas of good practice that can be built upon and spread both within the provider organisation but wider across the whole integrated system.

Considerable emphasis is placed upon executive and senior management leadership at this stage, underpinning the importance of both ensuring a culture and ethos that is responsive to the violence prevention, reduction and colleague health and wellbeing agenda. KPIs for this stage of the cycle are explored below:

## 6.1 Board reviews the violence prevention and reduction performance

Effective evidence that this KPI is being met is vital to providing assurances that both executive and senior management level colleagues are honestly appraised of the current performance of the violence prevention and reduction programme. This also ensures that where resources need to be allocated or diverted, this is explored, and necessary timely interventions are implemented to promote performance excellence.

**Prompts for this indicator include:**

- What executive level review process is in place that evaluates the performance and key functions of the violence prevention and reduction programme?
- Which executive(s) is taking leadership on this review process? How are they supported by the senior management team?
- Who makes up the senior management team? Reflect on if they are the right people in the right place at the right time for the role and the required leadership necessary to undertake that role.

**Take a moment to reflect:**

- How often is the violence prevention and reduction programme reviewed? Is this the minimum requirement or is there an active and proactive programme review that is engaging all stakeholders? How is this information shared with the executive team?

- What key lines of inquiry are formed by the executive team following review of the violence prevention and reduction programme? How are they communicated to the senior management team and wider stakeholders?

**Consider and appraise whether:**

- There is an open and transparent system developed to enable reporting to the trust board from the senior management team? Does this ensure that the board is appraised of any risks, mitigations and succusses?
- How are successes and areas of good practice 'spread' throughout the organisation?
- Is there executive level and senior management level sponsorship for good practice spread?

**Consider how:**

- Challenges to achieving success in the VPR process are identified and recommendations are made, specifically around resource allocation.
- Is the board able to identify what resources are required?
- Is there a strategy for resource allocation that will meet the needs and requirements of the violence prevention and reduction programme?
- If resources are not available in one form, could an alternative resource be considered?
- How is the issue of resource identification and allocation undertaken?

## 6.2 Violence prevention and reduction policy updated with lessons learned

Following successful executive and senior management review of the provider organisations violence prevention and reduction programme and ratification of future directions, a co-produced appraisal and implementation of updated policy and procedural suites should occur. This co-production as a minimum should include executive level sponsorship and oversight, senior management support and involve and engage those with primary responsibility for violence reduction and prevention within the organisation.

Prompts for self-assessment and organisational reflection at this stage may include consideration as to how the links between strategic decision making, tactical planning, and operational delivery are further developed, maintained, and strengthened.

Points to consider:

- Do you or the provider organisation have a critical friends' network that will assist with this self-assessment and reflection?
- What about opportunities for external stakeholder and independent audit arrangements that could assist in strengthening the organisation's violence prevention and reduction programme of work?
- What about project management for the various workstreams of the violence prevention and reduction programme: how are they arranged and managed? Do they follow the science of project management?
- Is there adequate support and resource from an executive level through to senior management level for all projects concentrating on the violence prevention and reduction strategy and programme?

## 6.3 Informed decisions at senior management level

The nature of informed decision making suggests that decisions are data and information driven reflecting the evidence and facts of a situation as they are understood at that time. Data and information flows and the intelligence generated from these should be assessed using effective methods to ensure consistency and efficacy.

Points to consider:

- What tools and methods of validation is your organisation using to appraise and assess the quality of data driven intelligence? Remember, data and intelligence may come from both internal and external information sources.
- Reflect on how your organisation gathers its data and intelligence; consider how it links in with key sources of data and intelligence such as local VRU, the ICS, NHS England and NHS Improvement, third sector and community-based organisations.
- Are these links proactively made and maintained with clear engagement from the right people? Consider how broad and comprehensive the provider organisations key stakeholder list is.
- Does this contribute to the process of informed decision making?

Fundamental to provider organisational commitment to colleague health and wellbeing is the development of an understanding or covenant that the organisation

will support colleagues who are affected by violence in any way, including for example colleagues who witness violent incidents. As such, prompts for reflection that the provider may wish to consider include evaluating the timeliness of and type of responses to violent incident investigations.

Points to consider:

- How does your organisation support colleagues affected by violence?
- What support is available? What form does it take?
- Does this support reflect any statutory duty where relevant?
- What happens when things are delayed and/or prolonged?
- Is the best practice model followed for (e.g.) the Victims Code of Practice? (The Code of Practice for Victims of Crime in England and Wales and supporting public information materials - GOV.UK (www.gov.uk)).
- What does stakeholder liaison and engagement look like here?
- What preventative multiagency approaches could be adopted to work with perpetrators of violence as part of a public health driven preventative approach?

# 7. Resources and links

- Ben-Shlomo et al. (2013). Epidemiology, Evidence-Based Medicine and Public Health. Wiley-Blackwell. Chichester.
- World Health Organization – Global status report on violence prevention 2014: Global status report on violence prevention 2014 (who.int)
- Social Partnership Forum – Social Partnership Forum
- Health and Safety Executive – Work-related violence - HSE
- Health and Safety Executive – Statistics - Violence at work (hse.gov.uk)
- Health and Safety Executive – Duty of Care: How do civil law and health and safety law apply? (hse.gov.uk)
- Health and Safety Executive – Health and Safety at Work Act 1974: https://www.hse.gov.uk/legislation/hswa.htm
- Management of Health and Safety at Work Regulations 1999: https://www.legislation.gov.uk/uksi/1999/3242/contents/made
- Health and Safety Executive – Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013: https://www.hse.gov.uk/riddor/index.htm
- Health and Safety Executive – Consulting workers on health and safety: https://www.hse.gov.uk/pubns/priced/l146.pdf; https://www.hse.gov.uk/pubns/books/l146.htm
- Deming Wheel – PDSA cycle: https://deming.org/explore/pdsa/#:~:text=The%20PDSA%20Cycle%20(Plan%2DDo,was%20first%20introduced%20to%20Dr.
- Care Quality Commission (CQC) – Care Quality Commission (cqc.org.uk)
- Equality Act 2010 – Equality Act 2010 (legislation.gov.uk); Equality Act 2010: guidance - GOV.UK (www.gov.uk)
- The Mental Health Units (Use of Force) Act 2018: Mental Health Units (Use of Force) Act 2018

**Annex 1**

## Relevant legislation

Several pieces of legislation demonstrate the general duty of care to protect staff from threats and violence at work incumbent upon NHS employers, including:

- Health and Safety at Work Act 1974
- Management of Health and Safety at Work Regulations 1999
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
- Safety Representatives and Safety Committees Regulations 1977
- Health and Safety (Consultation with Employees) Regulations 1996
- The Mental Health Units (Use of Force) Act 2018
- Equality Act 2010
- Protection from Harassment Act 1997
- Safety Representatives and Safety Committee Regulations 1977.

## HSE and CQC inspections

The Health and Safety Executive (HSE) undertakes inspections across all health sectors, and the Care Quality Commission (CQC) asks five key questions to all services they inspect:

1. Are they safe?
2. Are they effective?
3. Are they caring?
4. Are they responsive to people's needs?
5. Are they well led?

Achieving the key indicators of the VPR Standard will support provider organisations to meet statutory and legal obligations as employers, pertaining to colleague safety and wellbeing. Colleagues in provider organisations should:

- be protected from abuse and avoidable harm
- have safe and healthy working conditions
- have employers who have leadership, management and governance structures, policies and practices in place that encourage continuous learning to prevent future harm.

**Trade unions**

Trade union safety representatives can work in partnership with employers to support improvements in staff health, safety and wellbeing. When given the resources to carry out their role effectively, they can support the early identification and correction of unsafe conditions and working practices.

Under the *Safety Representatives and Safety Committee Regulations 1977*, employers must consult with trade union safety representatives in 'good time' on the following matters:

- the introduction of any measure at the workplace which may substantially affect the health and safety of the employees the safety representatives represent
- any health and safety information the employer is required to provide to the employees
- the planning and organisation of any health and safety training
- the health and safety consequences for the employees of the planning and introduction of new technologies into the workplace.

Consulting in 'good time' means before decisions are made, giving the safety representatives time to speak with members and report any concerns to the employer. Consulting the workforce and addressing their concerns is key to successful implementation of health and safety policies and risk reduction measures.

Under the regulations, safety representatives can investigate accidents, near misses and other potential hazards and dangerous occurrences affecting members in the workplace. They can also carry out regular proactive workplace inspections, or reactive inspections following changes in circumstances or incidents.

In practical terms, and with reference to the violence reduction standards, this means consulting safety representatives on the development of policies, strategies, training and risk assessments on work related violence. Carrying out joint investigations following physical or verbal abuse and joint inspections of the work environment to look at physical safety measures.

Where the organisation is introducing new technology to tackle violence, the organisation should consult with safety representatives on the planning and introduction of such technology. Safety representatives should be a member of any working groups or other forums established to tackle work related violence.

For further information, please see the NHS Employers and HSE websites.

Should you need further advice of support, please contact the Violence Prevention and Reduction Team at NHS England and NHS Improvement:

email: VP.AR@nhs.net

NHS England and NHS Improvement
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This publication can be made available in a number of alternative formats on request.