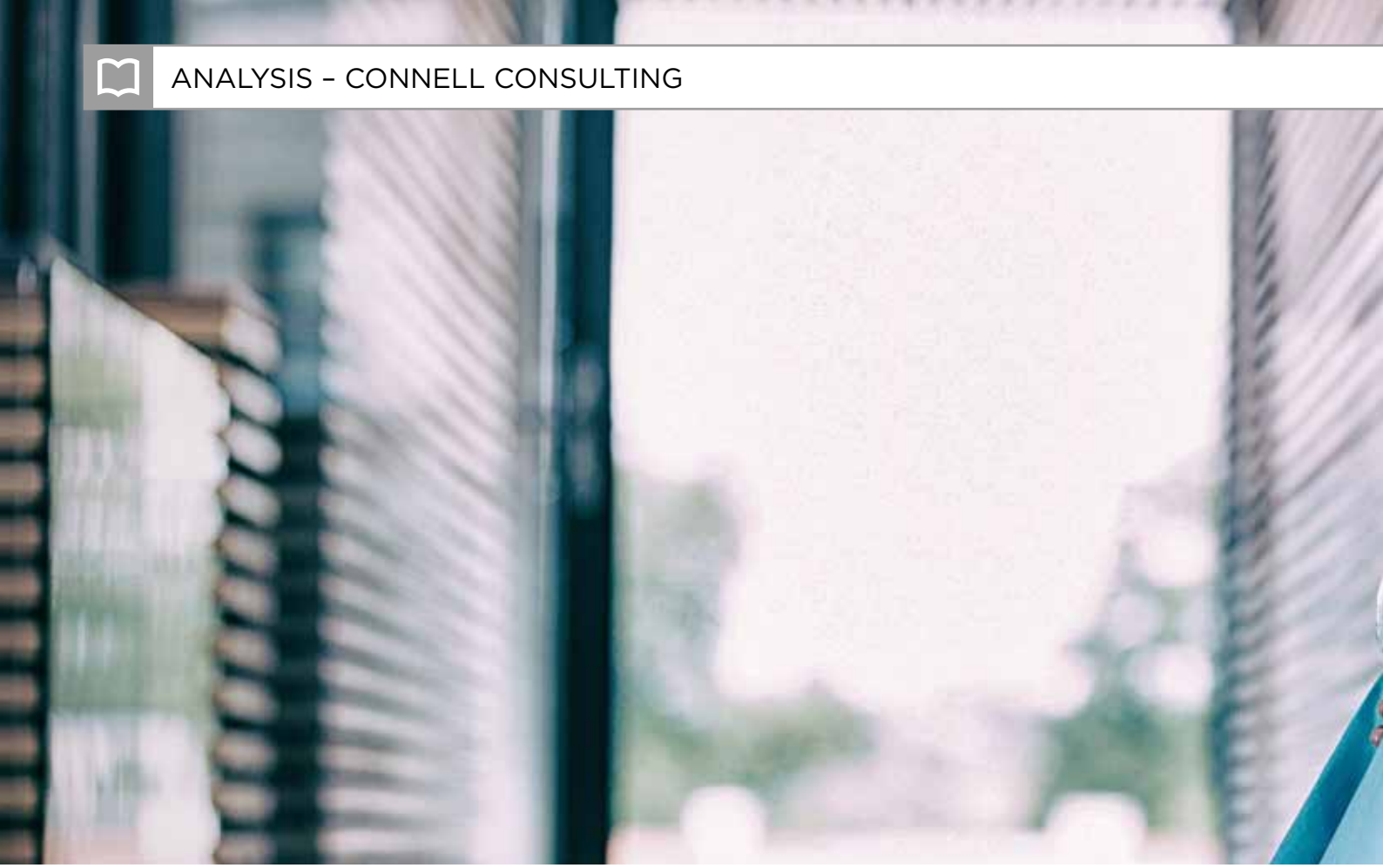


Connell Consulting

Under threat

With aggression towards health and care workers a key cause of staff turnover, **Clare Connell** and **Henry Hunt** of Connell Consulting look into what can be done to reduce it

Independent providers of care homes and hospitals can improve recruitment and retention through improving workforce safety.

One of the greatest concerns of staff working on the frontline of health and social care – and a major cause of staff churn – is their personal safety. Worryingly, there have been significant and widely documented increases in the rate of assaults and abuse of staff working in health and social care. Violence and abuse of staff impacts collective staff morale and individual motivation which, in turn, has significant knock-on effects on staff retention and absenteeism. If effectively addressed, providers may be able to reduce their own staff churn, or even seize an opportunity to poach workers from competitors that are less effective at making sure their staff feel safe.

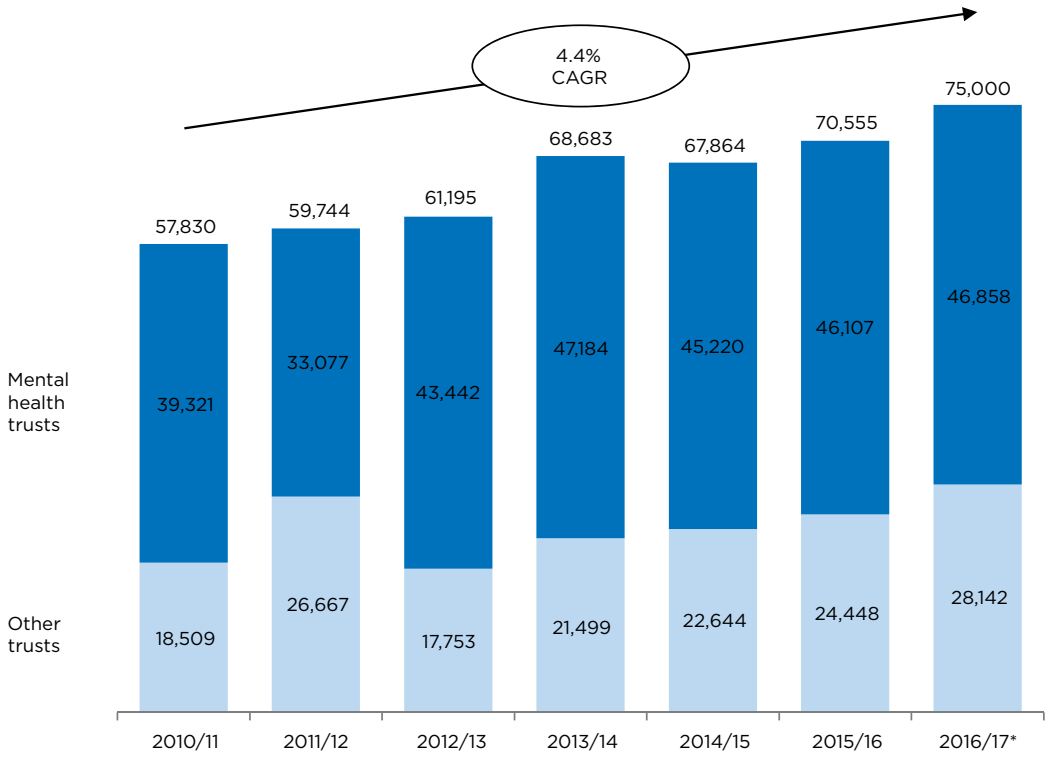
Rising violence

It's clear why frontline workers feel unsafe working in the health and social care sector. In 2016-17, approximately 75,000 violent incidents were recorded by NHS foundation trusts across England – that's over 200 a day. This figure represents the latest disturbing uptick in the incidence of violence in health services; in 2015-16 there were 70,555 reported assaults – an uplift of 6.3%. The prevalence of assaults has been increasing steadily over the last five years at a compound annual growth rate (CAGR) of 4.4% (*figure 1*).

It's not just a case of violence in NHS Trusts. A report produced by Skills for Care in late 2013 analysed the prevalence of violent assault and abuse in the social care sector in particular. One study which involved interviews with over 360 social care staff in an unnamed rural county, reported that 93% of staff had been verbally abused at some point in their employment, 71% felt threatened or intimidated, and 56% had been physically assaulted. It's worth noting that rural counties tend to have lower incidence of violence generally versus their urban ▶

FIGURE 1: VIOLENT ASSAULTS IN NHS TRUSTS

Number of reported physical assaults on NHS staff, England 2010-11 to 2016-17



- From 2010-11 to 2016-17 the reported incidence of physical assaults on NHS staff in England has increased at a CAGR of 4.4%
- In 2016-17 there were circa 205 reported physical assaults on NHS staff in England per day
- The majority of incidents occur in trusts dedicated to mental health. In 2016/17 mental health trusts accounted for 62% of incidents
- Staff in mental health trusts are seven and a half times more likely to be attacked than staff in other NHS trusts

**Data has historically been published by NHS Protect. This body has been replaced by the NHS Counter Fraud Authority and had its remit reduced – it no longer oversees the safety of NHS staff. Figures for 2016-17 have hence been produced by* HSJ *using freedom of information requests*

counterparts and, as such, prevalence indicated in this study may actually be fairly conservative compared to statistics for population centres.

The risks involved in working in health and social care are varied; 'physical assault' covers a range of incidents. In a special report from *HSJ* and trade union Unison, one nurse describes how she was on the receiving end of abuse and had been slapped by patients. She had also recently witnessed a colleague being punched in the face. Separately, Kim Sunley of the Royal College of Nursing notes "some horrible physical assaults – people being punched in the face, grabbed by the throat, limbs being broken, chairs being thrown at people".

In August of this year, Channel 4's *24 Hours in A&E* featured a mental health (MH) nurse at Princess Royal University Hospital run by Kings College Hospital NHS Foundation Trust. A patient had thrown boiling water on her face and neck, causing serious burns which required extensive treatment. She notes that she has been attacked by patients in the past.

Occasionally there are even more serious incidents. In 2003, Mamade Chattun, a psychiatric healthcare assistant, was beaten to death by a patient at Springfield Hospital in Tooting. In 2015, Jenny Foote, a care worker, was murdered by a resident at a mental health service in West London. In 2016, Patrick Clarke, a nurse at a South Croydon mental health hospital, was repeatedly stabbed by a patient and later died from his injuries.

Risk management

While the instances of violence within the health and social care sector are frequent and increasing, there are ways to effectively manage the risk associated with working in health and social care. These involve the careful monitoring and recording of incidents as they happen, the conscientious learning and development from those incidents and providing staff with the tools to feel safe. Moreover, providers can, and should be, risk averse with regards to the residents they allow in their services.

From an administrative perspective, having appropriate and regularly updated care plans for residents and patients is a prerequisite to effective risk management. The staff working within a service should have all the information available on the individuals they are caring for, with risk profiles associated with specific disabilities and health needs. For example, an individual with learning disabilities (LD) may simply lash out in frustration at not being understood by a care worker – if an individual has specific triggers to their frustration, and this is known prior to interaction, physical incidents harming either staff or resident are less likely to occur.

Someone with a personality disorder, psychosis or other mental health issue may represent a different risk; they might plan on hurting their care workers over an extended period of time. Jenny Foote was killed by patient Michael Meanza who said that she had asked him to turn down the volume on his TV and it was "the straw that broke the camel's back" after feeling as though care workers were overly controlling. The actual attack took place three hours after the request and involved the use of a fire extinguisher as a weapon.

Such carefully updated profiles of residents would allow providers and individual services to manage risk more effectively. For example, if a patient has been displaying paranoia and aggression toward staff, extra care should be taken to avoid access to potential weapons and safeguard staff. This might be a case of having external contractors or handymen supervised in their work, and all their tools accounted for when they leave, and it could be compulsory for all staff to wear personal alarms or be able to communicate with other workers at all times.

Systematic updating of resident profiles would be especially helpful to individuals who are not familiar with their wards. Agency workers and new staff would benefit greatly from comprehensive information on who they're caring for and the particular risks that they represent to staff and other residents, not having had the opportunity to develop their own experience.

Detailed reporting

As an extension of care plans for individuals, providers of health and social care services must develop a culture that encourages the reporting of the incidents themselves. Many stakeholders in health and social care do have systems and processes in place for the safeguarding of residents and staff, but often these include insufficient detail. Sometimes reports may only include the date of an incident and a one-word description or broad category like "altercation", or "assault".

Research undertaken by Skills for Care to assess organisations on their monitoring and recording systems for violence against social care and support staff indicated that 83% did monitor violence against staff, with 89% of those taking further steps to review and evaluate the information collected. The level of detail collected varied by respondent: 95% always collected information on the type of assault, 91% detailed who the assailant was, and only 79% collected information on the resulting action by the organisation (*figure 2*). While this data comes from local authorities, the trend is likely to be comparable to those in independently run hospitals or care homes.

Providers without robust systems in place to catalogue incidents suffer. It results in a two-fold problem; a lack of clarity regarding the scale and scope of the problem and a lack of understanding about the detail of the event, for example, what triggered the incident. Without measuring the problem, it becomes very difficult to make improvements. Moreover, if staff feel as though a concerted effort is not being made to monitor and improve staff safety, they're likely to feel demotivated; staff must see that their employer is doing all it can to protect them.

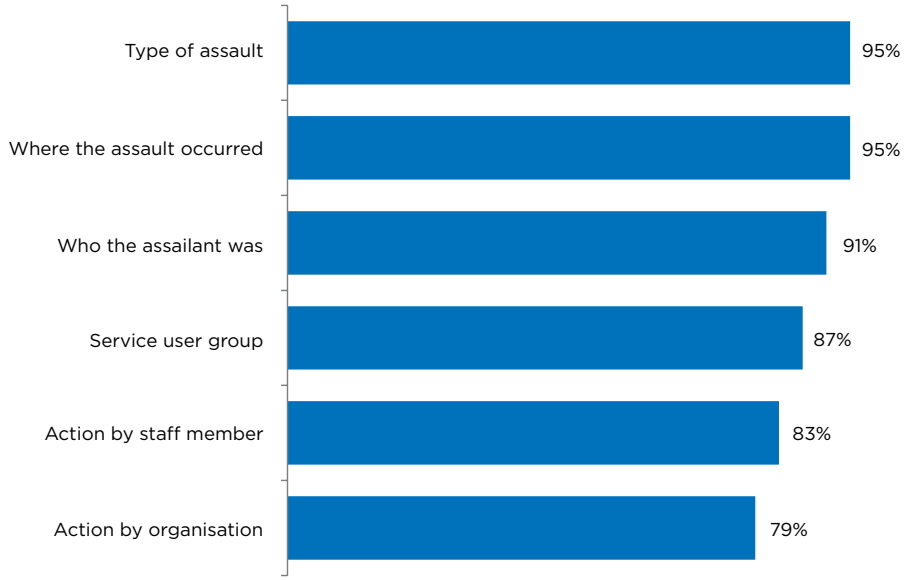
Targeted training is also vitally important to reducing the risks that staff are exposed to. The Skills for Care report into violence against social care workers noted that a common thread in the studies and surveys it analysed was that "lack of training" was seen as a real barrier to effective management of violence and abuse, and something that concerned care workers. Training might include understanding specific medical conditions and associated triggers to violence, developing de-escalation and conflict resolution techniques, as well as training in how to physically breakaway from patients.

Skills for Care looked at a range of in-house and external training such as 'understanding dementia' and 'conflict resolution and physical intervention' techniques. The most effective courses were those that also offered training in risk assessment specific to the appropriate cohort (such as LD, MH, dementia) as well as addressing particular issues. Importantly, care workers who had taken courses found that face-to-face training was much more effective than e-learning , which was deployed by some providers to limit costs; e-learning may be a false economy in light of the potential violence in a health and social care workplace. Effective learning and development has a key role to play in reducing the incidence of violence and abuse against social care and support staff.

It's important to note that training has the benefit of not only being effective when an incident occurs. If staff are trained in the skills to avoid or lessen the impact of violence, they will feel safer and more confident in their roles even if they never have the need to use that training. Understandably, when staff feel on edge or anxious that they are underprepared to deal with physical threats to themselves or others, performance falters and they may leave to assume a role they perceive to be safer. In

FIGURE 2: REPORTING AND MONITORING VIOLENCE

Level of detail collected following incidents of violence and aggression against social care workforce, England 2013



- Skills for Care undertook research of social care organisations and analysed the prevalence of monitoring and recording of violence and aggression against the social care workforce
- 83% of respondents indicated that their organisation does monitor incidents of violence and aggression
- Of those, 89% took further steps to review and evaluate the information collected
- However, the detail of monitoring and evaluation varied between organisations
- In 5% of cases, even the type of assault wasn't recorded
- In 9% of cases, the patient who had assaulted a staff member had not been recorded
- This lack of detail is not conducive to improving the violent state of health and social care

turn, when staff feel safe and self-confident, productivity and retention improves.

Competitive advantage

In the marketplace for frontline health workers, independent providers have a competitive advantage over NHS services in that they're capable of being selective of which patients they admit. While pressure might be applied by a clinical commissioning group or local authority to take high risk individuals they have difficulty placing, if a provider feels they pose too great a risk to their staff, and a risk that cannot be mitigated, then that individual should not be admitted. A trend over recent years has been the increasing acuity level of those entering into care services like hospitals and care homes. Individuals may present with co-morbid profiles with greater complexity of needs than ever before.

A driver of this trend has been the 'Transforming care' initiative - a policy that was designed to allow, as much as possible, individuals with disabilities (predominantly learning disabilities or autism) to live in the community, close to home, with as much as independence as possible. An impact of 'Transforming care' has been a shift of individuals into less secure homes, with less support, in the pursuit of greater freedoms. While an admirable goal, there might be occasions where individuals do not have enough support in their placement. They may be safer or more appropriately cared for in a more secure setting, but the mandate of living independently has taken precedence. The result is that some health and social care services have residents that staff are not adequately prepared to deal with. That might mean inadequate staffing ratios, inappropriate levels of training for those staff or it might be to do with the layout or construction of buildings. Historically, for example, much of the furniture in care homes might have been bolted down as a safety measure but, in order for residents to feel less institutionalised and more at home, this precaution is not as prevalent; in a violent altercation furniture can be, and is, used against staff.

Safety first

Individual services and their operators need to be clear about the limits of their capabilities, especially when caring for people with challenging behaviours or co-morbid profiles. For example, a home that predominantly cares for people with LD must be cautious about admitting a new resident who might present with a learning disability as a primary need but has additional diagnoses around mental health. Historically, such an individual may have lived in a low-secure hospital, but since 'Transforming care' has been guided toward an unlocked care home. A service should think carefully about whether it is willing to accept that risk of admission. If a service does admit such a resident, appropriate staffing and training needs to be undertaken to reduce the level of risk that staff are exposed to.

Employees will not put up with being permanently outside their comfort zone, with individuals they are untrained to work with. They will find new employment with a provider that is willing to engage in targeted training to increase their skillset that covers greater complexities. Or they'll find work with a provider that is conscious of only admitting residents that are within the existing capabilities of the staff team. Employees will also move on if they feel as though the service is dangerously understaffed. It is an irony that recruitment issues and high churn brings about greater difficulties in recruitment. However, this does represent an opportunity for well-organised and proactive providers who are engaged with making their staff feel safe. ■

Clare Connell is managing director at Connell Consulting, a strategy consultancy specialising in the health, social care and education markets.
020 7371 8142 / clare@connell-consulting.com

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