NHS Resolution

NHS Resolution Insights: Preventing and Managing Workplace Violence

Tuesday 7 October 2025
12:30 – 14:00

Advise / Resolve / Learn

Our 2025-28 strategy at a glance

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Who we are

We are part of the NHS, operating at arm's length from the Department of Health and Social Care.

Our services

Indemnity and Claims Management: Comprehensive cover and claims management for NHS services.

Advice: Supporting the NHS with concerns about practitioner performance.

Appeals: Offering impartial resolution of [illegible] contracting disputes.

Safety and Learning: Using the information we hold to support improvement.

Our priorities

Fair resolution

All of our services will focus on fair and timely resolution, keeping patients and healthcare staff out of litigation and other formal processes to minimise distress and cost.

Data and insights

We will contribute our unique data and insights to learn from harm and the response to harm across the health and justice systems.

Maternity and neonatal

We will draw on our unique position and work with our system partners to support maternity and neonatal safety improvements.

Our strategy is driven by our priorities, supported by our people and systems.

Our values

Professional: we are dedicated to providing a professional, high quality service.

Expert: we bring unique skills, knowledge and expertise to everything we do.

Ethical: we are committed to acting with honesty, integrity and fairness.

Respectful: we treat people with consideration and respect and encourage supportive, collaborative and inclusive team working.

Reflections and the law: how to use claims learning to improve staff safety

Justine Sharpe
Safety and Learning London Lead, NHS Resolution

Norman Challis
Technical Claims Lead, NHS Resolution

Reflections and review of WPV publication: 18 months on..

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Purpose:

1. **Identify and share insight into the volume, cost, causes and injuries associated with WPV**
2. **Identify age, sex, job role of staff, common themes**
3. **Disseminate the shared learning with members to use this as a driver for change improvement.**
4. **Shared with other NHS bodies to inform Policy and guidance.**

Findings:

- 5,287 claims 2010-2020
- Total cost of 4,674 closed claims = **£61.4 million**
- 63% closed with no damages paid
- 37% closed with damages paid
- Damages paid = **£31.3 million**

Since 2020... Claims headlines source: NHS Resolution FOI 6874

Employer liability where claim is closed and cause is ‘assault’ (seven financial years)

Year of Closure	No. of Claims	Damages Paid	NHS Legal Costs Paid	Claimant Legal Costs Paid	Total Paid
2017/18	165	3,583,227	754,963	2,822,312	7,160,502
2018/19	224	5,844,197	1,173,421	4,096,113	11,113,731
2019/20	244	7,734,444	1,283,875	4,238,626	13,256,944
2020/21	209	3,393,322	806,183	2,544,355	6,743,860
2021/22	180	3,393,484	704,505	2,735,636	6,833,624
2022/23	252	3,587,844	849,495	2,890,754	7,328,093
2023/24	222	3,819,034	609,679	2,899,961	7,328,674
Grand Total	**1,496**	**31,355,551**	**6,182,120**	**22,227,757**	**59,765,428**

Our call to action:

1.Use your Liability to third party scheme data to identify cost of claims relating to violence and share this with wider teams as a lever to improve staff safety.

2. Take a system approach to understanding the multiple factors contributing to claims and use these insights to support re-design.

Recap… high level findings from WPV report

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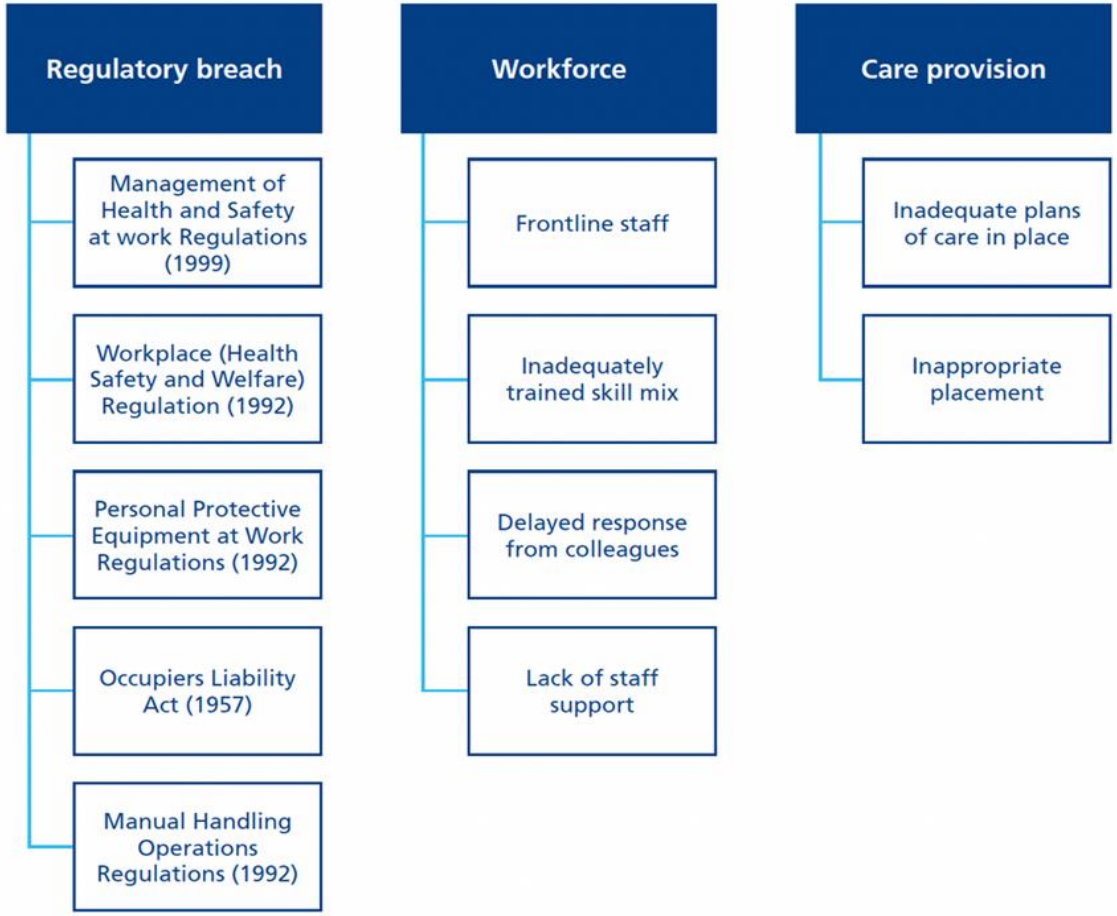
Figure 5: Most identified themes identified in the qualitative analysis of 40 successful claims



Our analysis of successful claims found that:

65% of those pursuing a claim for workplace violence were female and 35% were male.

41% of those pursuing a claim for workplace violence worked in a healthcare support role[b].

Mental health settings accounted for the highest volume of workplace violence in 58% of the successful claims.

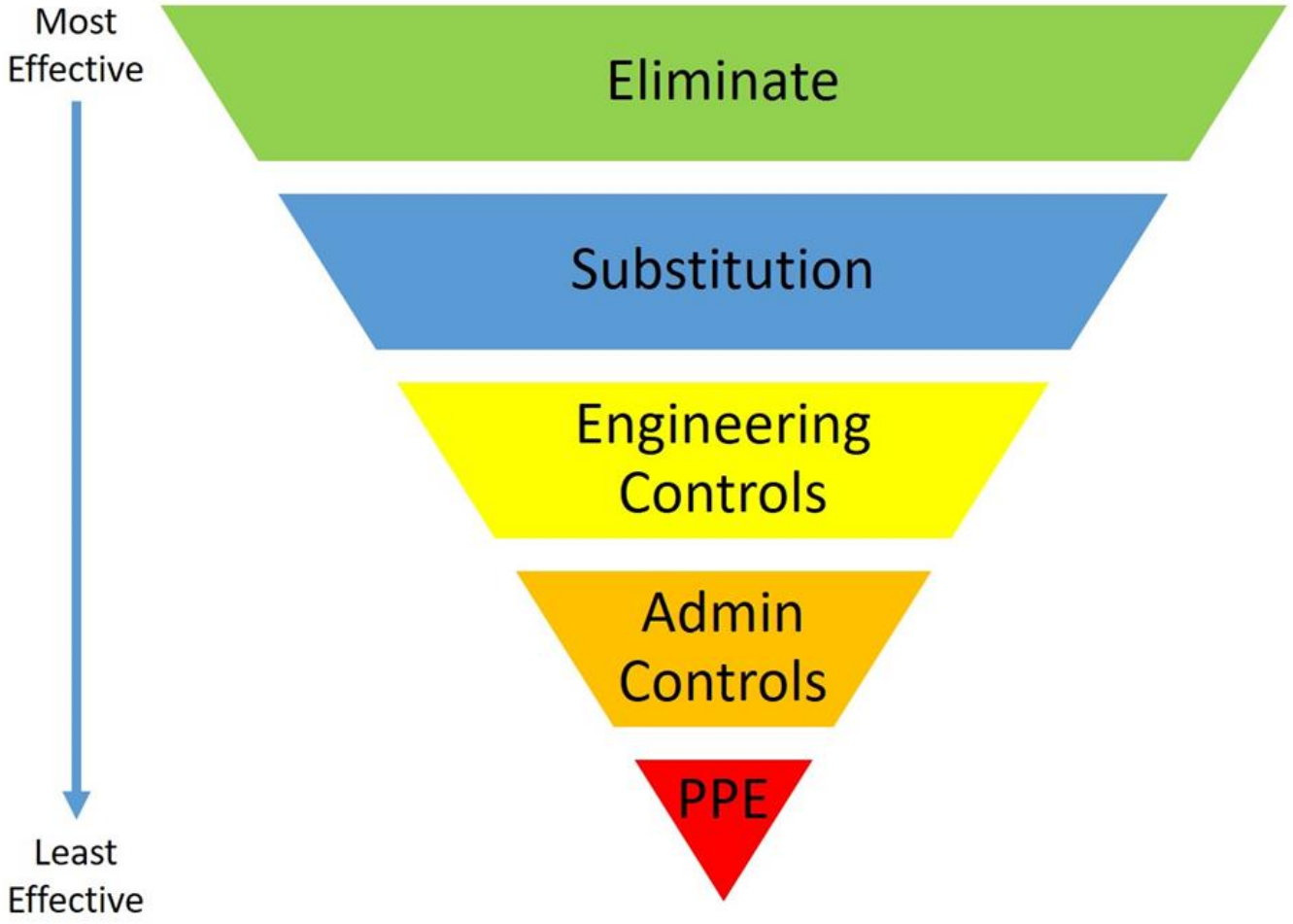
Orthopaedic injuries were most commonly reported and accounted for 56% of successful claims.

- The quality and accuracy of risk assessments were noted to be inadequate and did not acknowledge escalating risk of violence.
- Staffing levels often did not include an adequate number of people who had completed training in the prevention and management of workplace violence.
- Organisational policies and procedures on the prevention and management of workplace violence were not always in place.
- Organisational response and support to members of staff who have experienced workplace violence is variable.

Common observations and feedback from roll-out of WPV report

1. Claims learning points corroborate national findings and **reflects local LTPS risks.** Staff and managers largely unaware of NHS Resolution local data.
2. Barrier to improvement is **acuity** (e.g. staff shortage, competing priorities, money) and adequate **administrative controls**. So, getting buy-in difficult.
3. Structural organisation and reporting - challenges in progressing effective system wide improvement across organisation due to local line management reporting, hierarchies and common perspective.

What we mean by system change in WPV: Hierarchy of Controls:



Redesign high-risk pathways e.g. smooth patient flow, correct patient placement, lone-working
Adopt trauma-informed approaches instead of restrictive practice (RCT ↓ conflict ~15% and ↓ containment ~26%)
Safer ward, controlled access, reception barriers/screens, safe room, CCTV, fixed and mobile duress alarms. Targeted use of body worn video - impact context dependent and part of wider system.
Change way people work. NHS VPR standards, leadership, governance, data, robust reporting, workforce, interventions, violence checklist (e.g. Brøset) support for staff
Lone worker alarms and task specific protective equipment – aligned to local policy

How can we learn from claims

This is an illustrative case story based off themes found within workplace violence claims. The aim is to share the learning from these.
We encourage clinicians and organisations to reflect on how to prevent similar incidents, enhance patient safety and better protect staff.

Consider:

- Could this happen in my organisation?
- How are workplace violence risks managed, and are staff adequately supported in high-risk situations?
- Do I (my team) feel safe to escalate concerns?
- How effective is communication within my organisation?
- Who could I share this with?
- What can we learn from this?

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Illustrative ED case story – Workplace violence with damages paid

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1. Situation

- Senior triage nurse working alone in enclosed triage room
- Intoxicated patient brought in by police, left without security.
- Patient became aggressive.
- Personal duress alarm faulty. Delay in security arrival. Nurse sustained shoulder injury escaping room

2. Background

- Staff violence and de-escalation training up to date.

3. Assessment

- Absence of **engineering controls** (eg fixed alarm and dual exit room).
- **Administrative controls** e.g. risk screening, application of staffing policy
- Over reliance on least effective hierarchy of controls personal alarm **(PPE)**

4. Recommendation

- Safe working procedures documented, trained and enforced
- Safety critical equipment fixed
- Embed safety review into daily operational huddles – SEIPS helps reveal system factor beyond individual performance

So, what happened?

- Delayed repair of known safety-critical alarm fault.

Breach of Duty – Regulation 5 safe system of work

- No formal safe system of work for high risk triage assessment,

Causation

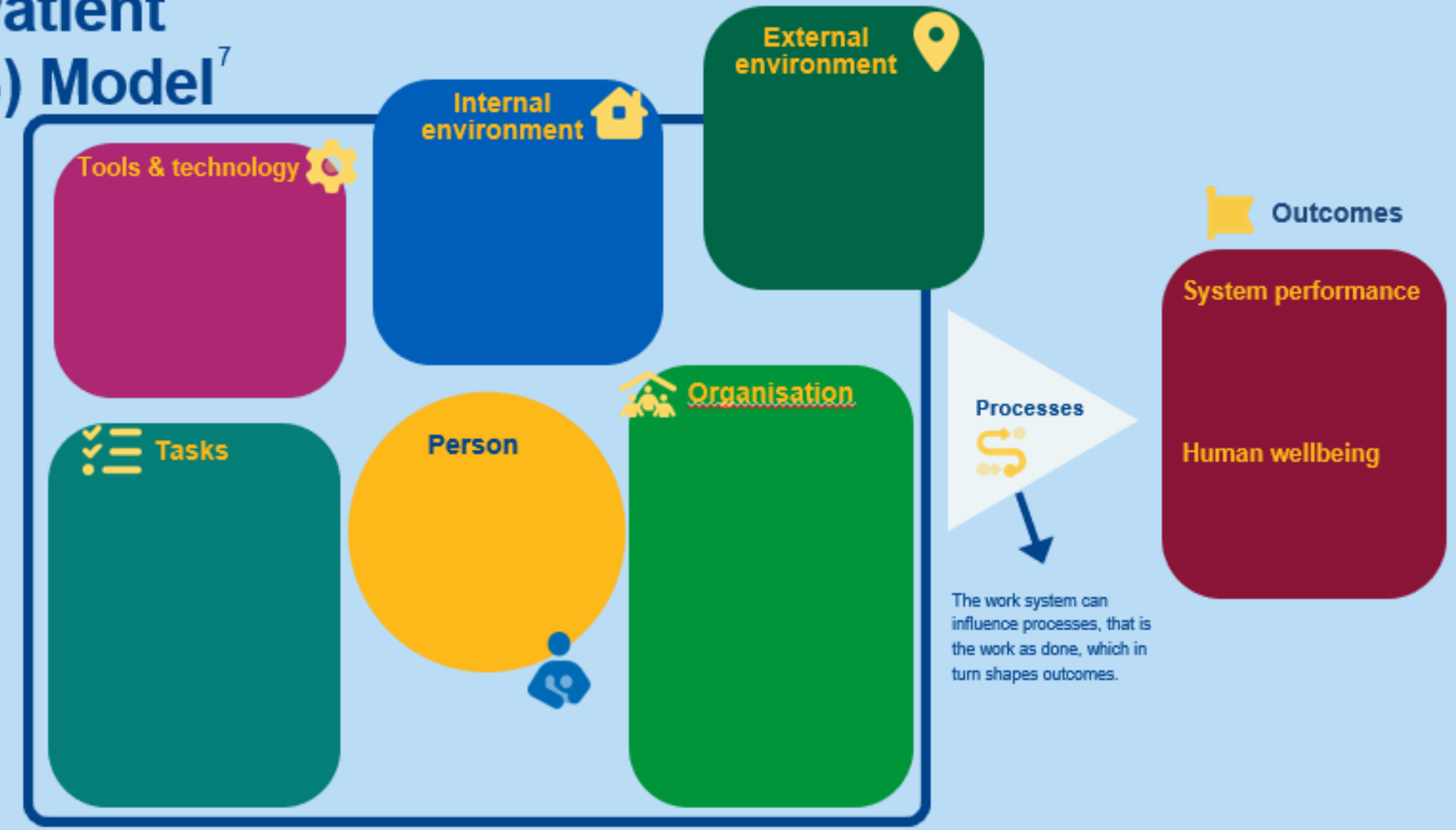
- Had the claimant had a working alarm there may not have been an injury

Injury

- Orthopaedic and claim for psychological damage

System Engineering Initiative for Patient Safety (SEIPS) Model[7]

The SEIPS framework is used here to demonstrate the potential for learning from this claim to support system-wide improvement.



Tools & Technology

- No fixed alarm; faulty personal alarm; no CCTV

Organisation

- Lack of 2-staff rule for flagged high risk cases;
- Implement escalation policies

Tasks

- Triage of high-risk patient without safety screen or security

Person

- Nurse had de-escalation training but worked alone

Internal environment

- Single exit, confined space (presumed ok because near public waiting area,

External environment

- Weekend and out of hours – multiple intoxicated arrivals.

Process

No arrival risk assessment
Faulty alarm unresolved

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Outcomes

Patient:
escalation to aggression; security

Staff:
physical injury sick absence psych distress

Organisation:
RIDDOR, HSE scrutiny, reputational harm

Illustrative MH case story – Workplace violence **with damages paid**

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1. Situation
- HCA returns from leave for night shift. Allocated to general observations.
- 2 RMN were administering depot which had not been given in day.
- While observingng patient struck HCA in face causing injury.
- Duress activated but delay response.

2. Background
- Handover had run late due to clinical acuity and staffing. Staff VR trained.

3. Assessment
- **Elimination - i**nappropriate patient placement. Adequate safeguard, escalating patient behaviour of concern.
- **Administrative controls change way people work** e.g. risk screening – patient unpredictability and history of violence not clearly passed between shifts. **PPE** – alarm. (culture of escalation)

4. Recommendation
- Safe working procedures handovers, revisit risks, .
- Safety culture – empowered to use alarm
- Embed safety review into daily operational huddles – SEIPS helps reveal system factor beyond individual performance

So, what happened?
- Inadequate risk assessment
- Inappropriate patient placement
- Delayed activation and response to duress

Breach of Duty – Regulation 5 safe system of work
- No formal safe system of work for high risk assessment, flagging risk to staff in advance (handover).

Causation
- Had the risk been shared there maybe no injury

Injury
- Facial and psychological damage

Illustrative MH case story – Workplace violence **successful defence**

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1. Situation
- HCA returns from leave for night shift. Allocated to general observations
- 2 RMN were administering depot which had not been given in day.
- While observing patient struck HCA in face causing injury.
- Duress activated but delay response

2. Background
- Handover had run late due to clinical acuity and staffing. Staff VR trained but no alarms provided.

3. Assessment
- **Elimination – N/A - a**ppropriate patient placement. Adequate safeguard, and process for escalating patient behaviour of concern.
- **Administrative controls change way people work** e.g. risk screening – patient unpredictability and history of violence clearly passed between shifts. (culture of escalation)

4. Recommendation
- Safe working procedures handovers, revisit risks, .
- Safety culture – empowered to use alarm
- Embed safety review into daily operational huddles – SEIPS helps reveal system factor beyond individual performance

So, what happened?
- Adequate risk assessment
- Behavioral triggers recorded in care plan and communicated to all staff

Breach of Duty – Regulation 5 safe system of work
- Late handover was not causative of the incident.

Causation
- Risk was identified and unavoidable. All relevant training and care plans in place.
- Provision of alarm not causative

Injury
- Facial and psychological damage

References for reducing workplace violence

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