

# Specification for a directed enhanced service

## Services to support staff dealing with violent patients

### Introduction

1. All Primary Care Organisations (PCOs) are expected to have access to a directed enhanced service to cover support services to staff and the public in respect of the care and treatment of patients who are violent. That service may, if necessary or appropriate, be in another local PCO area. The participation of the provider in a directed enhanced service must at all times be voluntary. PCOs should develop directed enhanced services in close consultation with Local Medical Committees (LMCs) or their equivalents.
2. The right of a practice to remove a violent patient will be extended to safeguard all those who might have reasonable fears for their safety. Once this has taken place (expected to be from 1 April 2004), these will now include members of the practice's staff, other patients and any other bystanders present where the act of violence is committed or the behaviour took place. Violence includes actual or threatened physical violence or verbal abuse leading to a fear for a person's safety.
3. Additionally, PCOs must ensure that they implement a zero tolerance zone campaign to send out the message to the public that aggression, violence and threatening behaviour will no longer be tolerated by professionals and staff working in the health service. PCOs should also develop a local action plan for combating violence in discussion with interested local groups. At a minimum, these would include the LMC (or its equivalent), the police, local Trusts and local statutory organisations for patient and public involvement in health care.
4. Depending on the gravity of the incident, it would also be open to the PCO to explore with the practice the additional support that might be provided to enable it to retain the patient on its list.

### The scope of the directed enhanced service

5. The directed enhanced service is for the provision of general medical services. It allows for the enhancement of resources for the provider of the service and the provision of services to a specified standard. When patients have been subject to immediate removal from a practice list, the provider is presented with the additional difficulty of treating the patient in a way that minimises the risk of violence or disruption to GPs, practice and attached staff and other patients. Handling these problems can make the delivery of general medical services difficult and can restrict the patient's access to wider facilities. These patients may also experience difficulties in securing registration with a practice without the help of the PCO. Additionally, such patients often have complex and wide-ranging health and social care needs.
6. PCOs in remote and rural areas may deal with very few or no violent patients. It is important to ensure that the arrangements which are set up under the directed enhanced service are appropriate for the number of violent patients likely to be involved.

### Aims

7. The purpose of a directed enhanced service for patients who have been subject to immediate removal from a practice's patient list is to provide a stable environment for the patient to receive continuing health care, addressing any underlying causes of aggressive behaviour and providing a safe environment for the individuals involved in delivering that treatment. The model does this by:
  - (i) incentivising providers to retain, on a longer term basis, those patients who are potentially aggressive and who have been removed from a practice's list because of their violent behaviour. The incentive provides the resources for the provision of essential and additional services, recognises the additional workload created by such patients and funds specific security investments required by the provider. The intention is to provide a stable environment in which the health needs of the patient can be addressed in a proper and continuing manner

- (ii) encouraging providers to work with other primary care practitioners, social services and other agencies to try to identify and treat any clinical and underlying causes of disruptive behaviour to prevent further deterioration
- (iii) promoting a continuing understanding of the NHS health and social care system to encourage the patient to use the services in a responsible, appropriate and safe way in the future
- (iv) safeguarding the families of patients who have been subject to immediate removal from a practice's patient list who are, on occasions, themselves subject to removal. Providing a stable environment for treating the patient will, just as importantly, have the effect of providing similar stability for any family members. The medical care needs of the families of patients who have been subject to immediate removal will need to be considered on a case-by-case basis. Often it will be appropriate for them to remain registered with the original practice, which should be protected by an injunction from approaches by the removed person on behalf of family members.

## Policy considerations

8. In commissioning a directed enhanced service, the PCO should ensure that the arrangements provide long-term medical care for patients who have been subject to immediate removal from a GP's patient list. The intention is that the provider of the service should normally maintain the patient's registration for at least twelve months. Shorter-term provision of care does little to address the health and social needs of the patient or promote the benefits of general practice to the patient.
9. The directed enhanced service should work within any local arrangements for dealing with violence that have been entered into by the PCO with the LMC (or its equivalent), the police, other agencies and other parts of the NHS.
10. The incentivising of the directed enhanced service will depend on the nature of the local arrangements for handling patients who have been subject to immediate removal from a GP's patient list. Patients may, for instance, be seen at a secure facility that is away from normal surgery premises. If provision is to be practice-based, the incentives might also fund security investments (for example, security guards and premises improvements). Finance for specific staff training is also beneficial to build up the confidence of all those who come into contact with the patient.
11. PCOs should be mindful of the need to protect patient confidentiality by avoiding, where practical, data flows which identify individuals. However, it is well recognised that there is an obligation to share information between professionals and agencies to ensure that appropriate services are provided and safe working practices are adopted. Doctors and providers should be encouraged to share information between health and social services agencies, prison, police and other relevant sources to build up a picture of past behaviour so that risk can be assessed.

## How would a directed enhanced service work?

12. When a practice requests the immediate removal of a patient because of an act or threat of violence the police must be informed in accordance with relevant regulations (paragraph 9A schedule 2 of the GMS regulations (England and Wales); paragraph 10, schedule 2 of the GMS regulations (Northern Ireland) 1997 and paragraph 9 of schedule 1 of the NHS (GMS)(Scotland) regulations 1995) and the PCO should be notified. The PCO is expected to notify the new provider of the history of aggressive behaviour. As part of this process, it is important that the PCO does everything possible to ensure that the new provider receives the patient's medical record before the patient has to be seen. PCOs are therefore in a position to identify those who have been violent in the past and to produce planning projections of the number of requests they might receive in the future.
13. PCOs should ensure that these potentially violent patients know about the new arrangements and register with the provider of the directed enhanced service and that appropriate security facilities are available to protect the provider and other patients. Such provision could occur in general practices, in hospitals, in police stations or in other suitable secure locations. Consideration should be given to minimising the possibility of home visits by providing patient transport services with police or security support. Such support should also be available if any home visits are undertaken because of clinical necessity, after a full telephone assessment of the patient's medical condition.

## **Clinical role**

14. The directed enhanced service should provide for a thorough assessment of the patient's clinical, psychological and social needs, especially those which may result in unrealistic expectations and which may have led to physically or verbally aggressive behaviour in the past.
15. The directed enhanced service should provide time to educate the patient and his or her family or carers on the best way to obtain good quality and continuing services from primary care in particular and the NHS in general. PCO input into this should be considered to demonstrate to the patient that it is the PCO which has decided to include the patient in this particular pattern of care.
16. Patients would need to be clearly informed that they were having care provided within the directed enhanced service specifically because of their previous violent behaviour. It should be made clear to patients that they are not being excluded from receiving primary care medical services but that their behaviour compromises their right to have access to normal arrangements and locations for receiving those services.

## **Review**

17. The provision of care to a patient within a directed enhanced service for violent patients should be subject to twelve-monthly review. This would be initiated by the provider and would give an opportunity to consider whether or not the patient should continue within the directed enhanced service. It would be supplemented by a more wide-ranging three-yearly review where the PCO might seek more substantive justification for a continuance - for example, that the patient could not learn new behaviour because of an underlying personality disorder.

## **Security**

18. In upgrading security, the provider's aim should not be to adversely affect the outward appearance of the premises where care is provided in a way which might make other patients uneasy about the security environment. Security should, wherever possible, be discreet but effective rather than overt.

## **Numbers of patients**

19. A directed enhanced service for patients who have been subject to immediate removal from a practice's list should be responsive to local conditions, such as the numbers of potential patients. Rigid maximum and minimum numbers are unlikely to be helpful. The aim should be to encourage providers to build up a special interest in and commitment to such patients while not placing too many violent patients into a single location as this could detract from the services available to other patients from that provider. PCOs are not constrained by patient choice in placing these patients with a provider.

## **Benefits**

20. GPs and practice staff will be more expert and confident in handling patients who have been subject to immediate removal from a practice's patient list. This outward confidence will also reduce the potential for conflict and hence reduce the risk of a violent or threatening response.
21. The patient should become better educated as to the impact of any anti-social behaviour on the caring professions and should learn to get the best from the NHS.
22. The patient, and where necessary his or her family, will get continuity of care through the provider of the directed enhanced service. This is especially important to counter impressions of abandonment by the NHS which may have been a cause of previous violent behaviour.
23. Patients will become aware that their only source of primary care is through the one provider and being disruptive will not get them a new practice or a new doctor or make them the centre of attention. Patients retain their right to approach any practice and seek registration, but it is likely that practices will be reluctant to take on a patient who has been subject to immediate removal from another practice's patient list. The PCO should always notify a new provider or practice that the patient has been removed under the contractual

provisions for immediate removal. PCOs are expected to ensure that they have access to a directed enhanced service for these purposes and to make practices aware that a directed enhanced service is in place.

24. The stability offered by the directed enhanced service will lead to an improved doctor-patient relationship in which both the patient and the doctor can work constructively together. The intention is to provide a wide range of health and social services.
25. Providers of a directed enhanced service will be recompensed for the additional effort and risk associated with providing medical care to potentially violent individuals.

## **Pricing**

26. In 2003/04, national benchmark pricing for the provision of this directed enhanced service suggests that general practitioners retained to provide the service should receive a retainer fee of £2000 per annum plus a consultation fee of £40 to £80 for in-hours consultation and £50 to £100 for out-of-hours consultation. In addition £2,500 per annum can be provided for infrastructure costs. These figures will be uplifted by 3.225 per cent in 2004/05 and again in 2005/06.