Scottish General Medical Services Provision for Patients Displaying Violent Behaviour: a Nationwide Comparative Review

October 2020

Scottish Government
Riaghaltas na h-Alba
gov.scot

SCOTTISH GENERAL MEDICAL SERVICES PROVISION FOR PATIENTS DISPLAYING VIOLENT BEHAVIOUR: A NATIONWIDE COMPARATIVE REVIEW

Helen Stacey, University of Edinburgh Medical School

ABSTRACT

The prevalence and impact of violence in primary care settings establishes its position as a key public health concern. Where patients are violent in primary care, and the Police informed, contractors are entitled to immediately remove them from their practice list. These patients then receive care in designated Challenging Behaviour Services (CBSs).

Across Scotland there is significant inter-service variation in CBS delivery. Through questionnaire responses from each CBS, this review provides a detailed comparative overview of current services to inform future discussions and facilitate individual service improvement. Areas of good practice, key challenges and possible solutions are highlighted.

Crucially, current Scottish CBSs not only ensure the ongoing provision of General Medical Services for those subject to immediate removal, they also provide services for other difficult patients and often engage in an active process of rehabilitation, suggesting a need to re-define their role to recognise their valuable contribution to violence prevention. At present, central data collection, evaluation and mechanisms to share ideas are lacking and this remains an important area for future CBS improvement. CBSs also face significant challenges around accessibility, safety, support and training; these must be addressed to ensure the ongoing availability and quality of these valuable services.

INTRODUCTION

Violent behaviour in primary care

Within the current General Medical Services (GMS) contract, violence refers to 'actual or threatened physical violence or verbal abuse leading to fear for a person's safety'[1]. While there is a lack of routine data collection regarding violent behaviour in primary care, and definitions of what constitutes violence vary, studies performed consistently demonstrate a significant prevalence of violent behaviour[2-4]. In 2013, of the 68,683 reported assaults on NHS staff, 25% involved primary care staff[5]. Annually, two-thirds of primary care staff report experiencing violence from patients, with only 4% of GPs reporting no such experience in a five-year period[6-8]. Moreover, there is growing concern that violence is increasing with crime rates in primary care rising[9]. This is echoed by concerns from 46% of GPs who believe patients are more violent than five-years ago, a change generally considered to reflect increasing pressures on primary care[6,10]. Violence in primary care is therefore considered a key public health concern[4].

Responses to violence in primary care – balancing zero-tolerance with a duty of care

In recognition of the potential physical and psychological impact of violence on healthcare staff and other patients, numerous government initiatives have been introduced, most notably the 1999 'zero-tolerance' policy which continues to underpin approaches to violence across the NHS[11,12].

Consequently, where a patient is violent in primary care, GMS contractors are entitled to immediately remove the patient from their practice list, provided the incident is reported to the Police (or Procurator Fiscal in Scotland)[1,13]. A Freedom of Information request to NHS Scotland's Practitioner Services Division revealed that in 2018 114 patients were subject to immediate removal across Scotland.

However, while individual contractors are entitled to remove patients from their practice list under these circumstances, such patients have a statutory right to ongoing care under the NHS Scotland Act (1978) which emphasises the universal right to primary healthcare[12,14]. There is therefore an ongoing responsibility to ensure the provision of GMS for this patient group until they are deemed able to return to mainstream services.

Scotland's approach

In Scotland, each of the 14 Health Boards is individually responsible for ensuring ongoing provision of GMS for those subject to immediate removal in their area[15]. Contractually, these arrangements are termed 'Violent Patient Schemes', although such terminology is controversial with the implication that these patients are inherently violent; the term 'Challenging Behaviour Services' (CBSs) is often used instead.

Each Health Board is free to decide how they will meet this responsibility. Consequently there is substantial variation in how CBSs are delivered across

Scotland. Indeed, a 2009 review of Scottish CBSs highlighted this variation gathering responses to five broad questions (Box 1)[16].

1. Details of the model used in your health board area.
2. How many patients are currently seen under these arrangements?
3. Cost per patient in the practice.
4. What is the process for 'rehabilitation'/risk assessment?
5. Describe the process for returning to mainstream general practice.

Box 1. Five questions addressed in 2009 review of Scottish Challenging Behaviour Services.

Review aims

CBSs are continually evolving and inter-board awareness of different approaches to delivery is currently limited. Given the importance and prevalence of violent behaviour in primary care, the present review therefore aims to update and extend the 2009 review.

Three key areas will be addressed:

1. How CBSs ensure ongoing provision of GMS.
2. How underlying issues are addressed with patients to facilitate long-term return to mainstream services.
3. How CBSs ensure a safe and supportive environment for staff and other patients.

The overarching aim is to establish current practice and inter-board variation, thus creating a detailed resource to act as a platform for future discussions about the shape of Scottish CBSs, with the ultimate aim of improving care for this patient group. By highlighting challenges, areas of good practice and identifying possible solutions, it is also anticipated this resource will be valuable for individual CBSs seeking to improve.

Furthermore, there is a lack of discourse and research within published literature on the underlying causes of violence towards primary care staff and the role of CBSs. This review therefore also aims to capture current perspectives from those involved in delivering CBSs.

METHODOLOGY

A questionnaire designed to capture the key elements of CBSs was developed in collaboration with NHS Lothian's CBS and the Scottish Government's Primary Care Division; 39 questions covered seven broad areas (Box 2; full questionnaire in Appendix 1).

Referral process

Service design

Accessibility

Return to mainstream General Practice

Service evaluation

Challenges encountered

Broader perspectives on violence in primary care and the role of CBSs

Box 2. Areas covered by questionnaire.

This questionnaire was distributed to Primary Care Managers in each Health Board. Where responses to questions were unclear, respondents were contacted for clarification.

RESULTS

Responses were obtained from 13 Health Boards (Appendix 2); NHS Shetland provided no response. NHS Borders, Grampian and Orkney indicated they did not have CBSs, although NHS Borders provided details of their planned service. NHS Greater Glasgow & Clyde runs two separate services, Glasgow and Clyde. NHS Highland also splits its provision of CBSs; a response was only obtained from Argyll & Bute. Thus 11 CBSs are considered herein.

Question One: Eligibility and referral process

While four CBSs strictly only see patients subject to immediate removal, the remaining seven described various circumstances under which other patients may be seen (Q1A&B):

> "On occasion there are patients who engage poorly or in a toxic fashion but who
> never the less may need an intervention or referral and we take these as well."
>
> **Ayrshire & Arran**

> "A patient who they (a practice) think has challenging behaviour."
> "Patients … who have been deregistered from their GP practice for unreasonable/violent behaviour"
>
> **Dumfries & Galloway**

> "Any incident where a GP, or his or her staff, are abused, threatened or assaulted in circumstances related to their work, involving an explicit, or implicit, challenge to their safety, well-being or health."

> "Patients who have been threatening where the Police have been called are more likely to be accepted onto the CBR register but this is not always the case. Each referral is assessed independently."
>
> **Clyde**

> "Patients who behave in an abusive, threatening, aggressive or violent way and do not respond to measures to contain this behaviour e.g. behavioural contract."
>
> **Lothian**

Details of the proportion of patients subject to immediate removal in each service were generally unavailable, although Forth Valley indicated that 44% (18/41) of their current patients met this criterion.

Each CBS described a unique screening process for referrals, with timescales for this process varying from a few days to four weeks (Q1F&G). During this referral process, arrangements are consistently in place to ensure ongoing GMS provision, although there is variation in how this is achieved (Q3C). Both the number of referrals received and accepted in the past year varied from 1 to 27 (Figure 1)

(Q1C&D). Although the documented 'referrals received' may underestimate the demand CBSs face:

> "This figure is not an accurate reflection as there are a large number of enquiries dealt with verbally, e.g. to enquire whether the criteria has been met. (Referring) practices have different levels of tolerance."
>
> **Tayside**

Moreover, Lothian identified the expectations of referring practices as among their main challenges:

> "Expectation of referring practices that extremely violent patients will be accepted and expectation of referring GPs that all referrals will be accepted. Awareness of referring practices that there are steps that they can take with the patients prior to referrals e.g. behavioural contracts."

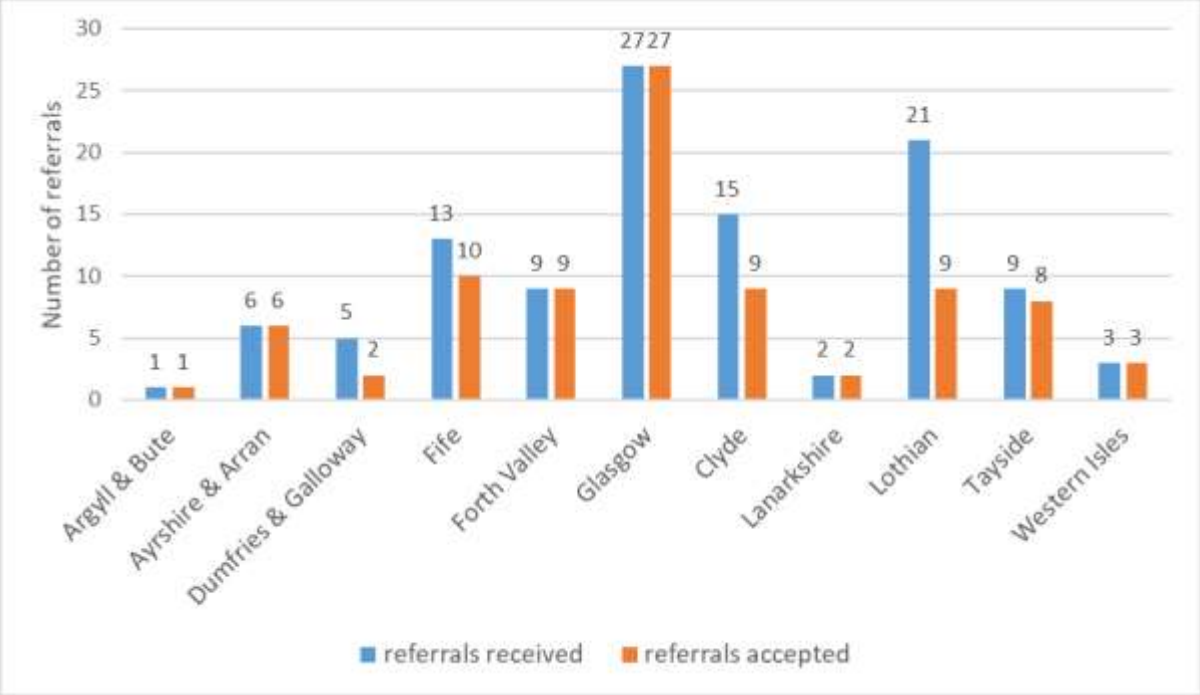

Figure 1. Number of referrals received and accepted by each Challenging Behaviour Service in the 12-month period between 01/09/18 and 31/08/19.

Referrals which were not accepted (25/111) generally represented difficult to manage, but not dangerous, patients; in these circumstances resolution was able to be achieved by other means (Q1E):

> "Requesting multiple prescriptions, verbally abusive, can be seen as aggressive and difficult to manage, patients with significant mental health issues. Primary Care worked with the practices to encourage and support further engage with patient and try and resolve the issues. An example could be to support the practice to meet with patient, setting up protocols between the patient and the practice to outline what is acceptable behaviour within the GP practice."
>
> **Dumfries & Galloway**

"These were difficult, but not dangerous patients. The referring practices were asked to keep them."

Fife

"Mainly verbal abuse or emotional response towards practice staff or other patients. Where there is no actual violence or threat of violence then the patient is not accepted. Patient will be informed by PSD that they have been removed from their GP list and will need to seek GP services elsewhere."

Clyde

"Referrals where not all avenues had been exhausted to dealing with the patients e.g. behavioural contracts. Or where referral to another agency would be more appropriate: e.g. addiction services or specialist dementia services."

Lothian

"Patient generally verbally abusive. Practice issued warning to patient that if behaviour continued they would be removed."

Tayside

Question Two: Service design

While Glasgow described designated service premises, the remaining CBSs are integrated within mainstream services: four in central out-of-hours/A&E departments and six within general practices (Q2D). Four CBSs operate from a single central practice while Clyde operate from three practices and the Western Isles from practices across the Uists and Barra. Argyll & Bute are forced to make interim arrangements for individual patients:

"Due to the remote and rural geography of Argyll and Bute we do not have permanent established Challenging Behaviour Services for the 28 GP Practices in the above 3 localities (in Oban Lorn & Isles, Mid Argyll Kintyre & Islay and Cowal & Bute). Alternatively, where incidences of violence occur interim arrangements are put in place as and when required. Frequently, the interim arrangements have to be put in place with the same practice that has removed the patient due to geography. An agreement is in place with NHSGG&C for the 5 GP Practices in Helensburgh & Lomond."

Argyll & Bute

While CBS patients in Dumfries & Galloway are seen in normal surgeries, simply with alerts in their records, the remaining 10 CBSs have security or Police present at appointments (Q2E). However, this is difficult to ensure in certain services:

"Police attendance at the patients GP appointments is a criterion of the contract agreement however due to the geography of Argyll and Bute and Police availability it is not always possible for the Police to attend. On occasion we have had the Police refusing to engage at all with the service. This makes the provision and implementation of the interim services DES very difficult."

Argyll & Bute

> "Police presence is requested for the clinic, however this is not always guaranteed." Main challenge of service identified as "risk to staff safety at clinic due to no Police presence".
>
> **Ayrshire & Arran**

In Clyde not all patients require Police presence, with patients evaluated and 'stepped-down' accordingly. Across services, where security or Police are present, they typically remain outside the consulting room, although in Glasgow security guards undertake additional security measures:

> "Our security guards use a dedicated private room for screening patients, offering them dignity and privacy when this is taking place. We use a hand held metal detector, and patients are requested to remove items from their pockets in a secure box until after their clinical consultation. We do not allow patient to retain their walking sticks or crutches as these have also been used as weapons. Patients can used walking aids to go to the clinical room for their consultation but these are then removed by security personnel and returned after the consultation."

Four services indicated they have also implemented other safety measures:

> "On occasion, practices providing the DES are offered advice from the local Community Police regarding the layout of the consulting room and changes that may assist with making consultations with violent patients safer."
>
> **Argyll & Bute**

> "The patient is seen in a room where there are 2 exits."
>
> **Forth Valley**

> "Patients are told that they must phone the practice and must not come into the surgery without an appointment even to pick up prescriptions or to accompany relatives or dependents."
>
> **Clyde**

> "The premises have also been inspected and recommendations made to ensure staff safety, e.g. panic alarms, room layout etc."
>
> **Tayside**

Within CBSs, patients are typically offered longer appointments (Q2F) and are seen by either a GP alone (n=7) or with a nurse (n=4) (Q2E), with other interactions generally managed by practice staff as for other patients (Q2C). Across CBSs patients are able to be referred as normal to other services while four services receive specific additional support (Q2G):

> "We have constant liaison with Forensic Psychology and Criminal Justice Service, together with ongoing support from our Clinical Director and Head of Homelessness. We have in addition to this, Forensic Psychology appointments on the same days as our CBRS Clinic, 2 per session."
>
> **Glasgow**

"If the patient assigned to the DES is currently being seen by other services then support may be provided during the patients inclusion. E.g. assigned patient being seen by Community Mental Health service then patient attendance at GP appointments may be supported by CPN in attendance instead of the Police."

Argyll & Bute

"Supported by Clinical Psychologist who offers fortnightly appointment slots at practice."

Lothian

"Some input from substance misuse services."

Western Isles

The number of patients currently registered within each CBS varies from 0 to 36, with service capacity also varying considerably (Figures 2 & 3) (Q2A). While most services indicated an ability to cope with current demand and additional capacity, Fife raised significant concerns:

"The increase in referrals is becoming too demanding for the capacity the practice has". This was also identified as the main challenge faced by Fife "Number of referrals at the highest they have ever been. The practice providing the service is threatening to resign from the LES due to this and we are concerned no one else will pick it up."

Moreover, Glasgow cited increasing patient numbers as one of their main challenges:

One of the main challenges the service faces is "access to this service, given that CRBS has tripled in size this year with a plethora of new patients."

Challenging Behaviour Service	Number of patients currently registered	Capacity (patient number)
Argyll & Bute	0	N/A
Ayrshire & Arran	33	40 1 hour/week, maximum 3 patients/session
Dumfries & Galloway	22	"more"
Fife	not provided	20
Forth Valley	36	N/A
Glasgow	75	monthly 40 patients, annually 480 5 appointments/session, 2 sessions/week
Clyde	29	no limit but depends on appointment availability

Lanarkshire	36	45 previously been able to be accommodated
Lothian	28	40 260 appointments annually
Tayside	8	N/A but 8 is highest ever accommodated
Western Isles	2	N/A but never had more than 6

Figure 2. Number of patients currently registered with each Challenging Behaviour Service and current service capacity.

Figure 3. Number of patients currently registered with each Challenging Behaviour Service.

The cost of each CBS also varies considerably (Figure 4).

Argyll & Bute	£750/patient
Ayrshire & Arran	£37,500
Dumfries & Galloway	£6,355, £192/patient
Fife	£20,000
Forth Valley	£25,000
Glasgow	£68,600, £1372/patient (2017 data)
Clyde	£26491, £914/patient
Lanarkshire	£44,428, £1,100/patient
Lothian	£76,800, £1,920/patient
Tayside	cost neutral
Western Isles	£2,333/patient, historically £10,000/year but costs increasing

Figure 4. Cost of each Challenging Behaviour Service in the 12-month period between 01/09/18 and 31/08/19.

Lothian and Glasgow were the only CBSs who described routine support available to staff (Q2I):

> "Clinical debriefs prior to all practice sessions with all CBGP staff. Meetings with Clinical Psychologist. Committee meetings – quarterly."
>
> **Lothian**

> "We are a small, tight team and our Lead Clinician and Clinical Director offer support particularly following upsetting and difficult engagement, this is also available following disruptive and abusive incidents. We are also offered

ongoing individual consultation with our colleagues at Forensic Psychology to "unload" following a challenging/abusive situation."

Glasgow

Clyde identified the lack of additional support as one of their main challenges. Although, as a number of services highlighted, all staff across CBSs would be eligible for occupational health support and several identified other support mechanisms that could be used:

"Primary Care team have a good relationship with the practice team providing this service, and if any concerns or guidance required by the doctors or any of the practice staff they would contact Primary Care team for support, and where necessary these would be raised with the Deputy Medical Director."

Dumfries & Galloway

"The staff would report any concerns to the Primary Care Manager/Associate Medical Director where appropriate support would be offered."

Forth Valley

"Staff members can speak to the lead GP and Practice Manager regarding any incidents or to raise concerns. Counselling."

Clyde

"Support from line manager is also available".

Lanarkshire

Furthermore, five services offer training to staff (Q2H):

"Team GP and Practice Nurse have both undergone breakaway training."

Ayrshire & Arran

"Personal safety training."

Fife

"All administration staff have been trained in violence reduction; stress at work and suicide prevention training."

Glasgow

"All staff have received violence and aggression training."

Lothian

"Aggression management training is arranged and provided for all staff required."

Tayside

Question Three: Accessibility

In 10 CBSs telephone advice is available during normal surgery hours. However, in Ayrshire & Arran contact is via an answering machine with responses given within 48

hours, a source of some complaints. Six services only offer appointments during restricted hours:

Ayrshire & Arran – 12pm on Tuesdays
Fife – 5-6pm week nights
Glasgow – Monday and Thursday 9.30am-12pm
Lanarkshire – Monday after 5pm
Lothian – Wednesday 11am-1pm and Friday 10.30am-12.30pm
Western Isles – typically after 6pm

The remaining five services place no restrictions compared to other patients (Q3A). However, for the four of these five services where security is required, the availability of security imposes some restrictions on availability. Moreover, appointment times are typically chosen with regard to the safety of other patients:

> "The GP will choose an appropriate time for the patient to be seen; this would usually avoid busy periods e.g. baby clinics etc., and we would also try to avoid times when other potentially disruptive patients may be present e.g. drug clinics."
>
> **Clyde**

> "Within core hours 8am to 6pm, although, actual attendance at the surgery is managed to ensure limited exposure to other members of the public - normally over a lunch time period or other time when there are few patients in the waiting room."
>
> **Tayside**

Across CBSs home visits are consistently not available (Q3D). Outside appointment times all patients are able to attend A&E, while patients from five CBSs cannot attend out-of-hours services (Q3B). Five CBSs indicated they notify these other services of CBS status via alerts.

Transport to CBSs is not provided, although three services reimburse travel expenses (Q3E). Tayside have received complaints regarding the need to travel to Dundee to access GMS.

Question Four: Return to mainstream General Practice

While the majority of services have no time limits or targets for return to mainstream GMS, Ayrshire & Arran indicated that "patients should spend no more than 12-months with the service" (Q4A). Data on the average duration patients remain in CBSs is not available, although responses indicated that there is substantial variation in duration, with decisions made on a case-by-case basis and some services retaining patients long-term. Across services, patients are reviewed for readiness to return at different intervals with decisions made individually by the GP (n=7) or by committee (n=4) (Q4D).

Each CBS has unique procedures for managing handover (Q4F&G). On discharge, patients are not typically able to return to their previous practice (Q4E). However this may be necessary in remote and rural settings, which is challenging:

> "Due to the geographical nature of Ayrshire & Arran, on occasion the patient will return to their original practice as this is the only practice that covers the patients home address. However, there is considerable resistance to this."
>
> **Ayrshire & Arran**

> "The geography of Argyll and Bute means that in the majority of cases the patient has to return to their previous practice."
>
> **Argyll & Bute**

Question Five: Service evaluation

Each CBS described a different approach to service evaluation (Q5C): seven indicated no formal evaluation process and four described a process of annual or periodic review.

For the majority (n=10), routine data collection solely centres around activity data including number of patients and costs, while audits and evaluation of patient experiences have not been undertaken (Q5A, D&E). However, Glasgow undertakes further data collection publishing an annual report; patient experience was also evaluated 14-months ago[17]:

> "We also utilise GP EMIS to collate data on attendance and issue D.N.A. (did not attend) letters to patients who do not keep their appointments. GP EMIS and Docman allow us to receive electronic documents for any patients who attend any A & E departments and this is also recorded on patients electronic records. For severely disruptive patients, and we have a few, we also collect data on the frequency of their calls to CBRS together with the abusive language and disruption they cause."

While there is a general lack of formal outcome evaluation, two services capture information on subsequent violent behaviour in primary care, although this data was unavailable (Q5B):

> "We carry out additional risk assessments when a CBRS patient causes an incident and record this on our own incident reporting system – Datix."
>
> **Glasgow**

> "The Primary Care team manage this service for the Board and would be made aware of any subsequent violent behaviour, annual reviews are undertaken by the DPCS practice to also capture this information and these reviews are considered by the Board."
>
> **Dumfries & Galloway**

Question Six: Challenges encountered

The main challenges highlighted by CBSs fall into five broad areas: sustainability and expectations, safety concerns, difficult patients, lack of support and training and remote and rural service provision (Figure 5) (Q6A).

Six services reported no formal complaints while three received complaints relating to the need to be seen in a CBS, with Lothian describing "a number of patients who see the care arrangements as a breach of their human rights". Other complaints received related to location, limited clinic times and access (Q6B).

Sustainability and expectations
"Sustainability – have required to contract with new providers on a number of occasions." **Forth Valley** "Number of referrals at the highest they have ever been. The practice providing the service is threatening to resign from the LES due to this and we are concerned no one else will pick it up." **Fife** "Access to this service given that CRBS has tripled in size this year with a plethora of new patients." **Glasgow** "Expectation of referring practices that extremely violent patients will be accepted. Expectation of referring practices that all referrals will be accepted. Awareness of referring practices that there are steps that they can take with patients prior to referrals e.g. behavioural contracts." **Lothian** "The inability to engage with clinicians willing to support the Health Board to operate the scheme. We had to arrange for a 2C practice to operate this scheme as despite much advertisement and encouragement, both incentive and financially wise, we could not establish an independent medical practice, or individual GPs to work with the Health Board to operate the scheme." **Tayside** "In Lewis & Harris, unwillingness of practices to participate in the DES." **Western Isles**
Safety concerns
"Interim DES arrangements being made with the same practice that removed the violent patient. Police non-engagement on occasion. Police availability to attend appointments." **Argyll & Bute** "Risk to staff safety at clinic due to no police presence." **Ayrshire & Arran** "Safety of administration team in reception area – registration desk is not fit for purpose. Mismatch between GP duty of care to protect staff from harm/provide safe working environment and patient need." **Lothian**
Difficult patients

"One or two drug seeking patients who live out with the practice area." **Dumfries & Galloway** "Ongoing patient behaviours particularly verbal abuse." **Forth Valley** "Patient's reluctance to accept that their own abusive and unruly behaviour was sufficient for them to be assigned to CBS. Unwillingness to attend and constant abusive phonecalls to advise why. Constant swearing and threatening phone calls from newly registered patients who do not want to engage with us. Constant verbal complaints from some patients who feel they should be prescribed opiates and controlled drugs. Refusal to follow protocols and patients arriving at other HSCP sites causing distress and disruption to services, even though they have been engaging at our current site." **Glasgow** "Dealing with abusive patients." **Lanarkshire** "Increasing number of angry patients." **Lothian**
Lack of support and training
"No additional support outside of the Police. Training for staff." **Clyde**
Remote and rural service provision
"Due to the remote and rural geography of Argyll and Bute we do not have permanent established Challenging Behaviour Services …. frequently, the interim arrangements have to be put in place with the same practice that has removed the patient due to geography." **Argyll & Bute**

Figure 5. Main challenges encountered by Challenging Behaviour Services.

Question Seven: Broader perspectives on violence in primary care and the role of CBSs

Drug-seeking behaviour was cited most often as the cause of violent behaviour (n=5) with other causes cited with varying frequency (Figure 6) (Q7A).

Drug-seeking behaviour	5
Lack of services to meet needs of patients with complex problems	3
Poor interaction and social skills	2
Unreasonable patient expectations	2
Frustration in obtaining appointments and not getting own way	2
Being denied sick lines or medication where needed	1
Not being listened to	1
Feeling let down	1
Feeling powerless	1

Figure 6. Perceived causes of violent behaviour and number of services citing each cause.

Patients seen in CBSs are also generally considered to have other underlying characteristics/problems: substance misuse (n=11), mental health (n=8), male (n=3),

ex-prison (n=2), anger management (n=2) and complex psycho-social needs (n=1) (Q7B). Other responses offer further insight into this group:

> "Individuals who are, on the whole, misunderstood and/or ill."
>
> **Ayrshire & Arran**

> "Often minor disgruntlement in patients with poor coping skills that simply need handling differently." Role of service described as to "make the patient realise the world and medical services are not against them."
>
> **Dumfries & Galloway**

While all services cited their role in providing GMS, many also described other roles centring around active rehabilitation (Q4B&C and Q7C&D):

> "The GP Practice should be taking steps to rehabilitate the patient to allow the patient to return to mainstream GMS when appropriate."
>
> **Argyll & Bute**

> "We explore the issues which led them to become involved with the service and treat those conditions that are amenable to such. At each appointment reference is made to the patient's pending return to GMS and how they might better relate to mainstream services."
>
> **Ayrshire & Arran**

> "Make the patient realise the world and medical services are not against them. Make the person feel treated normally with respect whatever is wrong and not label patient as a trouble maker."
>
> **Dumfries & Galloway**

> "This (addressing the underlying issues that led to a patients referral) is done opportunistically at consultations."
>
> **Fife**

> "Rehabilitation back to mainstream GP Practice, and addressing issues patient presents with – anger issues; abandonment issues; drug seeking behaviour; criminal activity; personality disorder. Baseline assessment … to assess the reason behind the disruptive behaviour which led to referral to CBRS."
>
> **Glasgow**

> "Patients challenging behaviour and its cause is addressed in appointments. Referrals to Psychology or Specialist Services as required. Patients are offered the opportunity to address circumstances: medical, social or relational that contributed to their challenging behaviour."
>
> **Lothian**

DISCUSSION

This review provides a detailed overview of the current shape of CBSs in Scotland, highlighting key inter-board variations and challenges in caring for this patient group. Identified areas of good practice/possible solutions to challenges have also been collated as a further resource for consideration by individual services (Box 3).

Behavioural contracts both within CBSs and as a recommendation for referring practices.

Designated phone lines for service patients manned by limited number of trained staff.

Appropriate support and training for all staff who interact with patient, including administration staff.

Debrief with all staff who interact with a patient prior to appointment to share concerns and potential issues.

Scheduling appointments for quiet times/when no other patients present.

'Stepping down' patients who no longer require security present.

Restricting patient access to service outside appointment times.

Security advice on additional safety measures e.g. room layout.

Reimbursement of travel expenses on request.

Alerts on records to notify other services of patient status, n.b. ethical issues surrounding confidentiality must be considered in this approach and informing patients is recommended[18].

Box 3. Identified areas of good practice/possible solutions to challenges faced.

At the outset it is imperative to appreciate that CBSs are continually evolving and this review only provides a snapshot of current services. Moreover, the responses presented are those of Primary Care Managers, not those directly involved in delivering CBSs, and the perspectives obtained are likely to reflect this. The questionnaire approach also imposes inherent constraints on the responses received; in some aspects apparent inter-service variation may reflect the detail of information provided rather than real-world differences.

Ensuring ongoing provision of GMS

Consistent with their contractual obligations, all Scottish CBSs ensure the ongoing provision of GMS for patients who are violent. However, across Scotland there are substantial variations in GMS accessibility relating to appointment times and location, both between Health Boards and in comparison to the general population.

Such variations raise important questions about the rights of these patients in accessing GMS and therefore the shape of CBSs[18]. The inclusion of patients who have not been subject to immediate removal within CBSs further adds to these questions. While the nature of needing designated CBSs means there will be inherent restrictions on access, this must be balanced with an approach that does not enhance the inequalities often already faced by this vulnerable group[14,18]. Where possible, approaches to mitigate these differences, e.g. provision of travel expenses, should therefore be considered. Nevertheless, while the restricted service access is a source of complaint for some CBS patients, anecdotally many patients also prefer these designated services.

How underlying issues are addressed with patients to facilitate long-term return to mainstream services

Contractually the role of CBSs is simply GMS provision[15]. Although it is difficult to capture the approach of services in questionnaire format, it is evident that the majority of services go beyond this, attempting to address the underlying causes of violent behaviour with a view to future violence prevention and successful long-term return to mainstream services. This important distinction raises the question of the need to contractually re-define the role of CBSs to encompass this; perhaps CBSs could be termed 'Challenging Behaviour Rehabilitation Services'. Such reconceptualisation may lead to a wider recognition of the value of these services within the broader public health framework of violence prevention[14], not least when considering the funding made available to them.

The increasing inclusion of patients not subject to immediate removal within CBSs further challenges the current contract. However, while the capacity to offer care to others may be incredibly valuable, there is a need to be careful this doesn't lead to a situation whereby GPs attempt to 'offload' all difficult patients to CBSs. Thus, any such shift must be balanced by empowering mainstream GMS to deal appropriately with difficult behaviour; this review identifies a number of means by which this could be achieved.

Meaningful comparison of the current cost of each CBS is considered to be precluded by the substantial variation in services offered and approach taken. Moreover, the general lack of data collection, outcome data and service evaluation surrounding CBSs represents an important gap, precluding appropriate evaluation of the role and effectiveness of these services. In future there is therefore a need for a consistent and comprehensive approach to this across services cognisant of not placing undue burden on staff.

How CBSs ensure a safe and supportive environment for staff and other patients

Underlying the contractual entitlement to remove violent patients from mainstream GMS is the recognition of the need to protect staff and other patients. However, this should also extend to those delivering CBSs. In some CBSs it is clear that such protection is lacking, with security not always available and staff often facing the challenges of dealing with ongoing difficult behaviour. While to some extent these challenges are unavoidable, security must be ensured and appropriate staff support and training provided[5]; at present this also appears to be lacking in some services.

These factors may underlie some of the difficulties in recruiting practices to take on CBSs, although this is likely to be an ongoing challenge requiring further consideration and strategic planning[17]. Consultation with those directly interacting with patients to understand their support and training needs would be valuable; crucially this must also extend to administrative staff who are often on the receiving end of continued verbal abuse and not just GPs.

Broader perspectives on violence in primary care and the role of CBSs

This review offers new insight into the causes of violence in primary care. While some of the causes identified are consistent with existing understandings of violence[5,14], some of the dynamics identified are unique to the primary care setting thus contributing understanding to a previously unexplored area. It is however acknowledged that this initial exploration is limited and those involved in delivering CBSs have a unique perspective on causes of violence in primary care which remains under-utilised.

An additional role for CBSs could therefore lie in using their insight and expertise to help mainstream GMS with violence prevention. Indeed, the demand and nature of referrals faced by CBSs suggests many mainstream GMS are ill-equipped to manage difficult behaviour, echoing previous research[2]. A greater understanding of the causes of violence may also engender a greater willingness to understand and engage with difficult patients, rather than seeking to remove them; although such a cultural shift within primary care would be difficult.

Alternative models of service delivery

With significant inter-service variation, an alternative approach would be adopting a uniform model across Health Boards thus ensuring a greater consistency. However, as this review highlights, individual services face unique demands and challenges and need the freedom to respond to these accordingly. While a uniform model may therefore be inappropriate, an ongoing central mechanism for sharing ideas and resources, alongside the central data collection and evaluation already proposed, would be an asset.

At present the majority of CBSs use a centralised model of care. While a dispersed model may overcome some of the challenges presented regarding accessibility[17], this may magnify other challenges. It may be more difficult to ensure safety and provide appropriate support and training within a dispersed model. Moreover, recruitment of practices willing to offer CBSs may be prohibitive given the recruitment difficulties already faced. This review does not capture how CBSs have evolved since their inception and it may be that other models have been used previously; considering this evolution may therefore offer further insight into the challenges of different models when considering models for the future. Comparison with services across the rest of the UK may also prove beneficial, although a lack of reviews in this area makes this challenging.

Conclusions

Across Scotland there is significant variation in how CBSs are delivered. This review provides a detailed overview of current services to inform future discussions, highlighting many excellent examples of good practice and offering possible solutions to key challenges faced.

Crucially, current CBSs not only ensure the ongoing provision of GMS for those subject to immediate removal, they also provide services for other difficult patients and often engage in an active process of rehabilitation, suggesting a need to re-define their role to recognise their valuable contribution to violence prevention. At present, central data collection, evaluation and mechanisms to share ideas are lacking and this remains an important area for future improvement. CBSs also face significant challenges surrounding accessibility, safety, support and training and these must be addressed to ensure the ongoing availability and quality of these valuable services.

REFERENCES

1 The Scottish Government (2018). The National Health Service (General Medical Services Contracts) (Scotland) Regulations 2018. Edinburgh, United Kingdom: Author. Available from: http://www.legislation.gov.uk/ssi/2018/66/contents/sld/made.

2 Wright, N. M. J., Dixon, C. A. J., & Tompkins, C. N. E. (2003). Managing violence in primary care: an evidence-based approach. British Journal of General Practice, 53, 557-562.

3 Judge, J., & Bolton, J. (2012). Violence in primary care. Primary Health Care, 23(10), 18-22. hppt://dx.doi.org/10.7748/phc2013.12.23.10.18.e806.

4 Conageln, P., & Gallimore, A. (2014). Violence prevention: a public health priority. Glasgow, United Kingdom: Scottish Public Health Network. Available from: https://www. scotphn.net/wp-content/uploads/2015/10/Report-Violence-Prevention-A-Public-Health-Priority-December-2014.pdf.

5 National Institute for Health and Care Excellence (2015). Violence and aggression: short-term management in mental health, health and community settings. London, United Kingdom: Author. Available from: https://www.nice.org.uk/guidance/ng10.

6 Cogora (2017). Primary Concerns 2016: the state of primary care. London, United Kingdom: Author. Available from: https://documentcloud.adobe.com/link/track?uri=urn%3 Aaaid%3Ascds%3A US%3Abfb93a3d-655b-44a3-9891-ceda28e4e171.

7 Elston, M. A., & Gabe, J. (2016). Violence in general practice: a gendered risk? Sociology of Health and Illness, 38(3), 426-441. http://dx.doi.org/10.1111/1467-9566.12373.

8 Koritsas, S., Coles, J., Boyle, M., et al. (2007). Prevalence and predictors of occupational violence and aggression towards GPs: a cross-sectional study. British Journal of General Practice, 57, 967-970. http://dx.doi.org/ 10.3399/096016407782604848.

9 Lacobucci, G. (2017). Violent crime at GP surgeries is on the rise, figures show. British Medical Journal, 358, j4236. hppt://dx/doi.org/10.1136/bmj.j4236.

10 The Medical Protection Society (2015). Challenging interactions with patients. London, United Kingdom: Author. Available from: https://www.medicalprotection.org/uk/ articles/mps-survey-reveals-46-of-gps-believe-patients-are-more-violent-and-aggressive-than-five-years-ago.

11 Department of Health (1999). Campaign to stop violence against staff working in the NHS: NHS zero tolerance zone. London, United Kingdom: Author.

12 Department of Health and Social Care (2015). The NHS Constitution. London, United Kingdom: Author. Available from: https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england#staff-your-rights-and-nhs-pledges-to-you.

13 The British Medical Association (2018). Removal of patients from GP lists. London, United Kingdom: Author. Available from: https://www.bma.org.uk/advice/employment/gp-practices/service-provision/removal-of-patients-from-gp-lists.

14 UK Public General Acts (1978). National Health Service (Scotland) Act 1978. Edinburgh, United Kingdom: Author. Available from: https://www.legislation.gov.uk/ukpga /1978/29/contents.

15 The Scottish Government (2017). GMS contract: 2018. Edinburgh, United Kingdom: Author. Available from: https://www.gov.scot/binaries/content/documents/govscot/ publications/advice-and-guidance/2017/11/2018-gms-contract-scotland/documents/ 00527530-pdf/00527530-pdf/govscot%3Adocument/00527530.pdf.

16 Williams, N. (2009). Challenging Behaviour Practices. Glasgow, United Kingdom: Author.

17 Glasgow Health and Social Care Partnership (2017). Options paper: Challenging behaviour rehabilitation service review group. Glasgow, United Kingdom: Author.

18 The British Medical Association (2016). The ethical management of violent patients in primary care. London, United Kingdom: Author. Available from: http://www.wales.nhs.uk /sitesplus/888/news/40161.

APPENDIX 1: QUESTIONNAIRE

Challenging Behaviour Services nationwide review

Request by Michael Taylor, Senior Policy Manager, Primary Care Division, Scottish Government

Please provide information below about your Board's Challenging Behaviour Service (Violent Patients Scheme) as part of a nationwide review aimed to establish current practice and guide future services.

Please provide as much detail as possible in your responses.

Please return to michael.taylor@gov.scot by Friday 11th October.

NHS Board:
Name:
Role:
Contact details:

Referral process
What are the criteria for referral to your service?
Do you only see patients who have been subject to immediate removal from their GP practice? I.e. instances where the police or procurator fiscal have been involved.
Please provide details of other circumstances under which patients are seen and approximate % of patients who fall into each category.
How many referrals did your service receive in the 12 month period between 01/09/18 and 31/08/19?
How many referrals were accepted in the 12 month period between 01/09/18 and 31/08/19?
Broadly describe the nature of the referrals which were not accepted and how these were dealt with.
How are referrals screened?
What is the timescale between receiving a referral and the first face-to-face contact with the patient?

Service design
How many patients do you see annually and what is your current service capacity?
What was your approximate annual cost per patient in the 12 month period between 01/09/18 and 31/08/19?
Describe how patients interact with/access your service.
Please include all members of staff patients have contact with eg. to make appointments or for enquiries etc.
Where are patients seen?
What arrangements are in place when patients are seen?
Please provide details of who is present, security arrangements and how other patients are protected eg. separate clinic times.
How many minutes do you have to see each patient?
What support/input do you have from other services?
E.g. Clinical psychology
Describe any additional training that staff involved in the service have received.
Please consider all staff who patients interact with e.g. reception staff, practice manager etc.
Describe the support available for staff involved in the service.
E.g. debriefing, mechanisms for raising concerns, access to counselling.

Accessibility
What times does your service operate?
Outside of these times, where can patients receive care?
E.g. are they eligible to access out of hours GP?
While waiting for their first appointment with your service, where are patients expected to receive care?
Do you offer home visits?
What transport arrangements are in place for patients travelling to access your service?

Return to mainstream General Practice
What is the average length of time that patients are cared for in your service? Do you have time limits or targets?
How does your service attempt to address the underlying issues that led to a patients referral?
What, if any, steps are taken by your service to rehabilitate patients into mainstream general practice?
How do you determine a patients' readiness to return to mainstream general practice?
Are patients able to return to their previous practice?
How is the handover process to the receiving practice managed/facilitated?
Is any ongoing monitoring or support provided for the receiving practice?

Service evaluation
What data do you routinely collect about any aspect of your service?
Do you collect any data on subsequent violent behaviour in primary care?
How do you evaluate your service?
Have you undertaken any audits of your service?
If so, please provide details and indicate whether you would be willing to share this data.
Have you evaluated the patient experience of your service?
Please provide details.

Challenges encountered
What are the main challenges your service faces?
If you have received complaints about your service, please provide details about the broad nature of these.

Broader perspectives on challenging behaviour services
Why do you think some patients are violent in GP settings?
What sort of patients are typically violent?
What do you think the role of your service is?
What does your service try to achieve?

APPENDIX 2: COLLATED RESPONSES

Please note that for NHS Borders to date there has been no challenging behaviour programme in place. The below responses are therefore based on the service specification that is currently being negotiated. NHS Borders aims to contract with a GP practice over the next couple of months to provide a service.

Question One: Referral process

A) What are the criteria for referral to your service?	
Ayrshire & Arran	Patients who cannot be seen in mainstream GMC Practice due to actual or risk of harm to GP/staff/patients in the Practice. Patients who are MAPPA CAT 1 Patients.
Borders	As per schedule 14 of the GMS contract the referral criteria is the following: 35. 'Where the Contractor wishes a patient to be removed from the Contractor's list of patients with immediate effect on the grounds that 35.1. the patient has committed an act of violence against any of the persons specified in clause 36 of this Schedule [GP or anyone on the practice premises] or behaved in such a way that any such person has feared for that person's own safety; and 35.2. the Contractor has reported the incident to the police or the Procurator Fiscal. the Contractor must notify the Health Board in accordance with clause 37 of this Schedule [within 7 days via Practitioner Services Division].'
Dumfries & Galloway	For patients who compromise the safety of Doctors and GP practice staff.
Fife	Referrals are reviewed by an Assessment Panel. They should be patients who have been subject to an Immediate Removal.
Forth Valley	The practice must report the incident to the Police or the Procurator Fiscal. Patients who are referred but not reported to the Procurator Fiscal or Police: These patient's inclusion will be considered by the GMS Performance Review Group on an individual basis. Specific reasons why patient has been assigned to DPCS should be documented.
Glasgow	We have very strict protocols for receiving and accepting new patients into the CBRS Practice:-

	- Firstly, the principal criterion for allocation of a patient to the CBRS is that he or she displays violent or threatening behaviour in a GP surgery causing physical harm, material damage or emotional distress to medical or administrative staff and / or other patients. - When this happens and the Police are called, immediately there is a Police Incident/Police Incident Number created, the patient is then contacted by Practitioner Services Division (PSD). - Once PSD have been in touch with our Lead Clinician, a clinical panel will review the patient's case and only then will the patient be assigned to CBRS.
Clyde	Any incident where a GP, or his or her staff, are abused, threatened or assaulted in circumstances related to their work, involving an explicit, or implicit, challenge to their safety, well-being or health.
Highland – Argyll & Bute HSCP	GP Practices in Oban Lorn & Isles, Mid Argyll Kintyre & Islay and Cowal & Bute Localities; Due to the remote and rural geography of Argyll and Bute we do not have permanent established Challenging Behaviour Services for the 28 GP Practices in the above 3 localities. Alternatively where incidences of violence occur interim arrangements are put in place as and when required. Frequently, the interim arrangements have to be put in place with the same practice that has removed the patient due to geography. The practice are paid in accordance with the Directed Enhanced Service (DES), Services to Support Staff Dealing with Violent Patients (Annual Retainer £2,131.20 per annum and Consultation Fee £750.00 per annum). GP Practices in Helensburgh & Lomond Locality; An agreement is in place with NHSGG&C for the 5 GP Practices in Helensburgh & Lomond to be covered by the NHSGG&C DES, Challenging Behaviour and Rehabilitation Scheme (CBRS). Patients removed following incidences of violence are assigned to Dr Euan Glen and Partners, Oakview Medical Practice, Alexandria. Payment of the annual patient fees are paid on a quarterly basis to NHSGG&C (£750.00 per annum). No retainer fee is paid.
Lanarkshire	When the NHS Lanarkshire Challenging Patient Service (CPS) was first established the criteria for referral was from a GP. A medical member of the committee which considered such referrals would discuss the referral with GP to ensure the appropriateness of referral, i.e. is there another solution that can be obtained without referral to Committee. An incident Reporting Form from the GP giving details of incident and why the patient requires to be referred to Committee would be reviewed. A recommendation would made by the Committee.

	There have been some changes to the referral process and this is considered by the GP who provides the service to the CPS.
Lothian	Patients who behave in an abusive, threatening, aggressive or violent way and do not respond to measures to contain this behaviour e.g. behavioural contract. Patients whose behaviour is such that they cannot be seen in mainstream GP services.
Tayside	NHS Tayside does not have a "challenging behaviour service", only a violent patient scheme as required by the Directed Enhanced Services directions. The scheme is only used for those that commit violence, including actual or threatened physical violence or verbal abuse leading to a fear of a person's safety. A formal complaint must be made to the Police about the patient's behaviour. Patients are not normally transferred to the scheme where their behaviour can be ascribed to a condition that is capable of being alleviated by treatment, e.g. the mentally ill.
Western Isles	We don't have a service; it is delivered via practices under the Violent Patient DES

B) Do you only see patients who have been subject to immediate removal from their GP practice? I.e. instances where the police or procurator fiscal have been involved. Please provide details of other circumstances under which patients are seen and approximate % of patients who fall into each category.	
Ayrshire & Arran	No, on occasion there are patients who engage poorly or in a toxic fashion but who never the less may need an intervention or referral and we take these as well. We also see MAPPA patients who we have been advised to register from the MAPPA co-ordinator within the board.
Borders	At present the intention is for patients that have been removed from practices. This would include a breakdown in the relationship as well as violent behaviour.
Dumfries & Galloway	No. A practice may contact the Primary Care Development Team and discuss a patient who they think has challenging behaviour which they consider may fall under the criteria of the DPCS. The practice require to complete a template and provide this to the Team. This is looked at initially by the Primary Care Development Manager and if required it is escalated to the Deputy Medical Director for a decision as to whether the patient should access services via the DPCS. Over the last 5 years we have had 6 patients referred to the DPCS who have been deregistered by their GP practice for unreasonable/violent behaviour.
Fife	Generally yes, but we do accept referrals in other circumstances.
Forth Valley	We see patients who have been referred to the GMS Performance Review Group for assignment to the DPCS. Currently we have 18 patients on the DPCS who have been removed immediately ie reported to the police/procurator. Currently we have 23 patients on the DPCS who have been referred by the GMS Performance Group.
Glasgow	Yes – We only see patients who fit the above criteria and have been involved in a Police Incident and have subsequently been removed from their mainstream GP Practice. Police incident details are then passed to Practitioner Services Division (PSD) for allocation to new GP in our case, CBRS.
Clyde	Patients are referred subject to request for immediate removal from practice. This is advised to the panel via PSD - this does not necessarily mean when Police or Judiciary are involved. It is based on the referral from the GP practice and each is assessed on the details provided by the practice on why they wish the patient removed. Patients who have been threatening where the Police have been called are more likely to be accepted onto the CBR register but this is not always the case. Each referral is assessed independently.
Highland – Argyll & Bute HSCP	The criteria for inclusion in the DES is that the violent incident must be reported to the police and a crime number obtained – 100%.

Lanarkshire	Not necessarily. Before a patient is accepted to the CPS clinic, an overall assessment as to their suitability is made. Whilst immediate removal would be a factor for consideration, it is not the only factor considered.
Lothian	No – referrals can come direct from their practice seeking advice – 20%
Tayside	Yes, as described above.
Western Isles	Yes, only patients subject to immediate removal, or with police involvement.

C) How many referrals did your service receive in the 12 month period between 01/09/18 and 31/08/19?	
Ayrshire & Arran	6
Dumfries & Galloway	5
Borders	N/A
Fife	13
Forth Valley	9
Glasgow	CBRS have received 27 new referrals during this period.
Clyde	15
Highland – Argyll & Bute HSCP	1
Lanarkshire	2
Lothian	21
Tayside	9 - This figure is not an accurate reflection as there are a large number of enquiries dealt with verbally, e.g. to enquire whether the criteria has been met. Practices have different levels of tolerance e.g. In the main, practices in Dundee city, deal with these patients as part of their daily routine, whereas semi rural and rural are extremely intolerant probably due to limited exposure. Although Perth city is an urban area, there practices are the least tolerant overall in Tayside.
Western Isles	3 patients across the isles

D) How many referrals were accepted in the 12 month period between 01/09/18 and 31/08/19?	
Ayrshire & Arran	6
Borders	N/A
Dumfries & Galloway	2
Fife	10
Forth Valley	9
Glasgow	We have received 27 new referrals to the CBRS service all of which were accepted following the standard clinical consultations.
Clyde	9
Highland – Argyll & Bute HSCP	1 to NHS GG&C CRBS
Lanarkshire	2
Lothian	9
Tayside	8
Western Isles	3 patients across the isles

E) Broadly describe the nature of the referrals which were not accepted and how these were dealt with.	
Ayrshire & Arran	N/A – all referrals accepted
Borders	N/A
Dumfries & Galloway	Requesting multiple prescriptions, verbally abusive, can be seen as aggressive and difficult to manage, patients with significant mental health issues. Primary Care worked with the practices to encourage and support further engage with patient and try and resolve the issues. An example could be to support the practice to meet with patient, setting up protocols between the patient and the practice to outline what is acceptable behaviour within in the GP practice.
Fife	These were difficult, but not dangerous patients. The referring practices were asked to keep them.
Forth Valley	N/A
Glasgow	No referrals were refused. Patient behaviour unacceptable, and behaviour led to Police being called. Only when there has been a Police recorded incident does CBRS then become involved.
Clyde	Mainly verbal abuse or emotional response towards practice staff or other patients. Where there is no actual violence or threat of violence then the patient is not accepted. If the Panel decline the patient onto the Scheme the GMS Officer will advise PSD by email. Patient will be informed by PSD that they have been removed from their GP list and will need to seek GP services elsewhere.
Highland – Argyll & Bute HSCP	N/A
Lanarkshire	N/A
Lothian	Referrals where not all avenues had been exhausted to dealing with the patients e.g. behavioural contracts. Or where referral to another agency would be more appropriate: e.g. addiction services or specialist dementia services.
Tayside	Patient generally verbally abusive. Practice issued warning to patient that if behaviour continued they would be removed.
Western Isles	N/A

F) How are referrals screened?	
Ayrshire & Arran	Information will come via the Healthboard Primary Care Management Team in relation to a patient being assigned to the service. The CBS Team GP will consider content of the referral and will advise suitability for acceptance to the service based on information provided.
Borders	The Primary Care Contracts Manager will notify the Associate Medical Director when a patient is removed from a practice (PSD inform the NHS Borders) & a Patient Risk Panel will be formed to evaluate.
Dumfries & Galloway	GP practice wishing to refer patient require to complete a template providing information on patient and circumstances as why the wish patient to be considered by the Board as a DPCS patient. Once template received Primary Care works with practice to see whether the patient can be managed by their current practice and introduce procedure that the patient requires to adhere to. More complex cases are considered by the Deputy Medical Director for a decision to be made as to whether patient requires to access future services via the DPCS.
Fife	As above, by our Assessment Panel.
Forth Valley	Primary Care Manager/Medical Contracts officer – Immediate removals which have been reported to the police or procurator fiscal. Performance Review Group – referrals which have not been reported to the Police Procurator Fiscal.
Glasgow	All referrals are screened by a Clinical Panel, consisting of Lead Clinician for CBRS; Clinical Director and Doctor of Forensic Psychology, only when clinical panel agree, does PSD receive a notification of acceptance of the patient to CBS.
Clyde	- GMS Contract Officer emails the CBR panel for their opinion/decisions on inclusion onto the Scheme. The Panel individually will consider all the information and provide their views by email back to the Group on whether they consider the inclusion of the patient to be appropriate. - The Chair (HSCP Clinical Director) of the Panel will consider and review these responses and agree the consensus course of action. - PSD are advised whether the patient has been accepted or not. - Decision taken will be ratified at the next scheduled meeting of the Panel.
Highland – Argyll & Bute HSCP	Practitioner Services Division, Glasgow send the "Violent Patient Removal" (VPR) request form, which is completed by the removing practice, then forwarded to the Primary Care Assistant Manager who confirms that a crime number has been provided. The VPR form is reviewed by Associate Medical Director, Locality Clinical Lead and Primary Care Manager.
Lanarkshire	Referrals are screened by the GP who provides the service to the CPS.
Lothian	Committee based decisions based on information extracted from the referring practice on the patient

Tayside	Practices either contact Primary Care Services Dpt or Practitioner Services. If the latter, Practitioner Services draw to the attention of Primary Care Services seeking consideration of immediate removal.
Western Isles	Not screened; rely on practice judgement

G) What is the timescale between receiving a referral and the first face-to-face contact with the patient?	
Ayrshire & Arran	CBS Team GP will review medical records of all incoming patients. Based on this information the GP will make an informed decision as to whether patient requires an appointment at clinic or contact can be made via telephone. There is no hard and fast rule, each patient is different due to their individual needs
Borders	This process has not been tested yet, however, would estimate this should be concluded within a two period.
Dumfries & Galloway	The Board try and act immediately on receiving information from a practice. The Board do not have face-to-face contact with the patient. If it is felt that patient can be managed in current GP practice the Board will provide help/guidance to the Practice Manager. If it is decided patient must only access service via DPCS they will receive a letter and protocol for accessing the service to their home address.
Fife	No more than 5 days.
Forth Valley	We do not hold this information – it would depend when the patient makes an appoint to see the DPCS GP
Glasgow	This is set at 10 days of receiving the accepted referral and new patients are always appointed with the Lead Clinician in the first instance.
Clyde	The referral is received into PSD from the concerned practice. They immediately forward the referral by email to the GMS team to circulate to the panel. Once decision is made, the patient is written to by PSD to advise that they must attend a designated CBR GP practice. This would usually happen within 48 hours. They will be allocated a CBR practice based on the geographical area they live in. It is up to the individual to access the practice to have a face-to-face contact on their own timescale by booking an appointment, etc.
Highland – Argyll & Bute HSCP	Variable – as soon as possible once all the paperwork is processed and patient assigned. (few days to a couple of weeks max)
Lanarkshire	This will vary from patient to patient however it could be within a week.
Lothian	2 – 4 weeks
Tayside	The standard letter which PSD send to the patient to advise of immediate removal and why, informs the patient to contact the 2C practice which operates the Violent Patient Scheme on behalf of NHS Tayside. The 2C practice arrange a mutually suitable time with the patient for induction to the practice.
Western Isles	

Question Two: Service design

A) How many patients do you see annually and what is your current service capacity?	
Ayrshire & Arran	There are currently 33 patients on our service. Our aim is to keep the service below a maximum of 40-patients registered at any one time. Our CBS clinic runs for 1 hour per week with a maximum or 3 patients per session.
Borders	Patient numbers are estimated at 5. The service capacity will be a maximum of 15.
Dumfries & Galloway	Currently the service has 22 patients. There is capacity for additional patients.
Fife	Our service is run by one general practice as a LES. Their capacity would be 20 patients.
Forth Valley	2 GPs and other Admin Staff. We have 36 patients currently registered on this service. At present we do not have service capacity - there are no set appts available per week - appointments will be given when required.
Glasgow	The Glasgow scheme currently has 75 patients registered. We have 5 appointments per session, with each consultation lasting 25 minutes with Clinician and Practice Nurse. One session Monday morning and next session Thursday morning. We have in additional to this, Forensic Psychology appointments on the same days as our CBRS Clinic, 2 per session. Monthly – 40 patients Annually – 480 patients Forensic Psychology appointments – approx. 60
Clyde	Currently see 29 patients over the 3 practices. Capacity has no limit as such, would just depend on availability of appointments, etc.
Highland – Argyll & Bute HSCP	N/A
Lanarkshire	The current number of patients registered with the CPS clinic is 36, it has accommodated as many as 45 patients.
Lothian	Service capacity 40 – seen in the last year

Tayside	The eight patients currently registered with the scheme is the highest figure ever since inception of the scheme in 2004. We had to arrange for a 2C practice to operate this scheme as despite much advertisement and encouragement, both incentive and financially wise, we could not establish an independent medical practice, or individual GPs to work with the Health Board to operate the scheme.
Western Isles	Currently, only 2 patients registered. Low number of patients historically. Have never had more than 6 patients at any one time.

B) What was your approximate annual cost per patient in the 12 month period between 01/09/18 and 31/08/19?	
Ayrshire & Arran	Our Service is run as a Practice Specific Enhanced Service which comes with a budget or £37,500 paid to the practice in 12 monthly instalments.
Borders	N/A
Dumfries & Galloway	£192 per patient.
Fife	The practice is paid £20k per annum, paid in monthly instalments.
Forth Valley	The cost (based on 2019-20) will be £25,000.
Glasgow	The services has changed model during this as the GP practice running the GP element withdrew and the service is currently being directly managed by the HSCP. Costs for this period would therefore not be representative. However, please see attached review document for some consideration of costs.
Clyde	Annual cost - £26491 Annual cost per patient - £914
Highland – Argyll & Bute HSCP	£750.00 per annum.
Lanarkshire	Costs for the last full year were £44,428, the average number of patients was 40 during this period, the approximate annual cost per patient is £1,110.
Lothian	Currently have 28 patients 260 appointments
Tayside	Cost neutral as operated by 2C practice. However, we do have to pay a small amount of money on an ad-hoc basis if security services have been required. This is minimal.
Western Isles	£2,333/patient....

C) Describe how patients interact with/access your service. Please include all members of staff patients have contact with eg. to make appointments or for enquiries etc.	
Ayrshire & Arran	The service provides a telephone answer machine facility for patients to call to request appointments, advice and order prescriptions. These messages are responded to within 48 hours. Should the patient feel there concern/need is an emergency they would present to accident and emergency Prescription requests once complete are posted out to the patient chemist of their choice 1st class.
Borders	Patients will make appointments by telephone with the contracted GP practice providing the service.
Dumfries & Galloway	Mainly seen by the GP nominated lead for this service – both telephone and face to face. Most patients from outwith the Dumfries area will consult by phone which isn't always ideal but accepted due to distances involved, this makes accessing GP easier. Other GPs in the practice may see patients if necessary, unless patient is considered particularly challenging. Depending on requirement Practice Nurses will also see patients. Alerts on practice system to highlight DPCS patients.
Fife	They call the practice direct but have a different number from the routine patients. They are not seen in the practice but in the local A and E, with security present. Consultations are always with a GP.
Forth Valley	Patients contact a mobile telephone number or by e-mail – This is manned by a Practice Manager and 2 GPs
Glasgow	We have a dedicated telephone number for patients and their families to access – 0141 314 6261. We also letter all patients to confirm their appointment times and follow up with phone calls to confirm their attendance.
Clyde	These sections are answered individually by each GP practice: Practice 85403 – Patients make telephone contact with reception, and are advised that the GP will call them back to assess their needs and make appropriate arrangements to be seen. Practice 86271 - Patients are told that they must phone the practice and must not come into the surgery without an appointment even to pick up prescriptions or to accompany relatives or dependents. When they call, an electronic message is sent to the designated GP with a request to call the patient back. The doctor will call the patient and assess their needs. If an appointment is required, then it is booked and police arranged with the reception staff if required.

	Practice 87490 - Patients contact the practice by telephone and are offered appointments by the receptionist. It is highlighted to the receptionist that the person is on the CBR scheme and they will often be given a double appointment and organise a Police presence. Patients can also book a telephone consultation.
Highland – Argyll & Bute HSCP	Varies from practice to practice.
Lanarkshire	Patients book an appointment with reception staff as they would normally do at a conventional GP practice.
Lothian	Designated clinic twice a week – Wednesday and Friday, hosted within a mainstream GMS practice. Appointments made and processed by administration team Confirmation issued by administration Appointments can be made by patients – processed by administration team Scripts / telephone consultations – processed by administration team administered by GP or CPN Patient appointments with CPN and GP
Tayside	Once on the scheme, patients are free to contact the 2C practice at any time, as with any patient. The practice manages the patient's attendance, normally over a lunch time period or other time when there are few patients in the waiting room.
Western Isles	Practice staff deals with appointments etc.

D) Where are patients seen?	
Ayrshire & Arran	The clinic is held within the Ayrshire Urgent Care (OOHs) service rooms within Ayrshire Central Hospital, Irvine.
Borders	There are only 2 safe rooms within NHS Borders that comply with regulations. These are both on the Borders General Hospital site (in the A&E department and at Huntlyburn).
Dumfries & Galloway	Within the DPCS GP Leads own GP Practice
Fife	As above.
Forth Valley	Forth Valley Royal Hospital – Accident & Emergency Department
Glasgow	Dedicated centralised premises. We operate on a strict appointment only service, and give an allowance of 10 minutes either side of patients allocated appointment time. If patient arrives out with the allocated appointment time, they are not seen.
Clyde	85403 - In the GP's room in our main surgery 86271 - In the GP's room in the health centre 87490 - Patients are seen in the GP surgery premises in ordinary consulting rooms. If police is required (for step up patients), the officers wait with the patient in the corridor waiting area until they are called. Police normally remain outside the consulting room and accompany the patient out of the premises once the consultation is over.
Highland – Argyll & Bute HSCP	Majority in the GP Practice providing the service. Occasionally arrangements are made for the patient to be seen in the local Hospital by a GP.
Lanarkshire	Patients are seen at the CPS clinic which is located in Blantyre Health Centre, Blantyre.
Lothian	Boroughloch Medical Practice – consultation room has two access doors. Building has lock down facility.
Tayside	Whitfield Surgery, Whitfield Local Care Centre, Dundee
Western Isles	Depends on location. In Lewis & Harris, patients are seen in A&E in Western Isles Hospital. In the Uists & Barra, patients are seen in the various practices

E) What arrangements are in place when patients are seen? Please provide details of who is present, security arrangements and how other patients are protected eg. separate clinic times.	
Ayrshire & Arran	The CBS Team GP and Practice Nurse both attend the clinic. Police presence is requested for the clinic, however this is not always guaranteed. Alternative security solutions are currently being looked into.
Borders	We have not confirmed the exact details yet but will train several hospital porters in security techniques to ensure security is available by appointment as required. We will be looking at how the patient accesses the service via reception/separate waiting area etc. prior to implementation.
Dumfries & Galloway	No special precautions apart from alerts in records. Response is proportionate and patients seen in normal surgeries. Works well this way as GP Lead has experience of working 20 years as a forensic medical examiner. The practice's Assistant Practice Manager is a retired police inspector which helps on occasions, but is rarely required.
Fife	We have a designated time slot and consulting room in A and E, and security are in attendance . Patients are given set appointment times.
Forth Valley	1 GP Present Security is within the hospital The patient is seen in a room where there are 2 exits – one exit if the GP require to leave the room in a emergency.
Glasgow	We operate every clinic with the presence of 2 security guards. Our guards and our clinicians use dedicated rooms within a clinical and locked corridor which no other service users can access without being brought through by their own clinician. Our security guards use a dedicated private room for screening patients, offering them dignity and privacy when this is taking place. We use a hand held metal detector, and patients are requested to remove items from their pockets in a secure box until after their clinical consultation. We do not allow patient to retain their walking sticks or crutches as these have also been used as weapons. Patients can used walking aids to go to the clinical room for their consultation but these are then removed by security personnel and returned after the consultation. We also have a member of the admin team for CBRS present at every clinic, they utilise a separate multipurpose admin room.
Clyde	85403 - The GP will choose an appropriate time for the patient to be seen; this would usually avoid busy periods eg baby clinics etc, and we would also try to avoid times when other potentially disruptive patients

	may be present e.g. drug clinics. The waiting area in our main surgery has full CCTV coverage. if the patient has Full CBR status, arrangements are made for the Police to be present in the waiting area, and if deemed necessary they may come in to the consulting room, or wait directly outside the door (this is rarely necessary) 86271 - A Police presence in the building. 87490 - Patients are seen in the GP surgery premises in ordinary consulting rooms. If police is required (for step up patients), the officers wait with the patient in the corridor waiting area until they are called. Police normally remain outside the consulting room and accompany the patient out of the premises once the consultation is over.
Highland – Argyll & Bute HSCP	A contract agreement between the GP and the patient is required to be signed at the first consultation. The contract agreement specifies that the patient must telephone in advance and make it clear that special arrangements are in place for their GP appts. Police attendance at the patients GP appointments is a criterion of the contract agreement however due to the geography of Argyll and Bute and police availability it is not always possible for the Police to attend. On occasion we have had the Police refusing to engage at all with the service. This makes the provision and implementation of the interim services DES very difficult.
Lanarkshire	The normal arrangements for the clinic is for a GP and CPN to see a patient. There is also a police presence within the clinic however the police don't sit in on the consultation with patients. The clinic is provided at times when no other patients would be in the area.
Lothian	Separate clinic from mainstream patients. Security guard on site. Dedicated administration team. Dedicated GP and CPN.
Tayside	As above
Western Isles	Appointments are often, but not exclusively, after 18.00

F) How many minutes do you have to see each patient?	
Ayrshire & Arran	10 minute slots available. Maximum of 3 booked appointments per clinic. All appointment must be Pre-booked with service, however this is not always adhered to and extra patients arrive at clinic without warning. This is discouraged but is a regular occurrence.
Borders	This will be at the discretion of the GP; however, this is estimated at 30 minutes per patient appointment.
Dumfries & Galloway	20 minutes for first appointment, normally thereafter 10 minute appointments.
Fife	Variable, but normally 20 minute appointments.
Forth Valley	We do not hold this information
Glasgow	Each patient appointment is scheduled for 25 minutes.
Clyde	85403 – 15 minutes (longer if necessary) 86271 - 20 minutes 87490 – 10 minutes
Highland – Argyll & Bute HSCP	The appointment time is at the discretion of the practice.
Lanarkshire	Initial consultation 45 minutes, 15 minutes thereafter
Lothian	20 mins (40 mins for new patients)
Tayside	Managed by the practice.
Western Isles	No set times

G) What support/input do you have from other services? E.g. Clinical psychology	
Ayrshire & Arran	Nil
Borders	This is still being explored with input anticipated from Mental Health Teams & the addiction service.
Dumfries & Galloway	Nothing formal, but GP Lead has good links with forensic psychology and to prison as the practice cover the prison as well.
Fife	None other than OOH who see the patients evenings and weekends. GPs can refer to other specialties as they would for their routine patients.
Forth Valley	Patients would be referred to appropriate services if required.
Glasgow	We have constant liaison with Forensic Psychology and Criminal Justice Service, together with ongoing support from our Clinical Director and Head of Homelessness.
Clyde	We have support from Police Scotland. Staff contact the Police service to request a Police presence during consultation. Other than this there is no other support services.
Highland – Argyll & Bute HSCP	If the patient assigned to the DES is currently being seen by other services then support may be provided during the patients inclusion. E.g. assigned patient being seen by Community Mental Health service then patient attendance at GP appointments may be supported by CPN in attendance instead of the Police.
Lanarkshire	Patients are referred to other services as required.
Lothian	Supported by Clinical Psychologist who offers fortnightly appointment slots at practice. Committee members – various healthcare professionals and agencies represented on Committee.
Tayside	The practice accesses the same services as they would do for any other patient. There is not a separate arrangement for patients registered under the scheme. Aggression management training is arranged by the Practice Manager and provided for all staff as required by way of trainers from a local Mental Health Hospital. The premises have also been inspected by this trainer and recommendations made to ensure staff safety, e.g. panic alarms, room layout etc.
Western Isles	Some input from Substance Abuse service

H) Describe any additional training that staff involved in the service have received. Please consider all staff who patients interact with e.g. reception staff, practice manager etc.	
Ayrshire & Arran	CBS Team GP and Practice Nurse have both undergone Breakaway training.
Borders	It is anticipated that GP, practice nurse & security (porters) will require training in management of violent & aggressive patients.
Dumfries & Galloway	No additional training
Fife	Personal safety training.
Forth Valley	No training received
Glasgow	All administrative staff have been trained in violence reduction; stress at work and suicide prevention training. We are also offered ongoing individual consultation with our colleagues at Forensic Psychology to "unload" following a challenging/abusive situation. We also have ongoing support from GP IT for systems.
Clyde	No additional training
Highland – Argyll & Bute HSCP	On occasion, practices providing the DES are offered advice from the local Community Police regarding the layout of the consulting room and changes that may assist with making consultations with violent patients safer.
Lanarkshire	No specific training provided
Lothian	All staff have received violence and aggression training.
Tayside	As described above.
Western Isles	

l) Describe the support available for staff involved in the service. E.g. debriefing, mechanisms for raising concerns, access to counselling.	
Ayrshire & Arran	Nil
Borders	Access to occupational health services (including counselling), debriefing sessions with the Associate Medical Director & awareness that issues can be escalated to the Associate Medical Director/Medical Director as appropriate.
Dumfries & Galloway	Primary Care team have a good relationship with the practice team providing this service, and if any concerns or guidance required by the doctors or any of the practice staff they would contact Primary Care team for support, and where necessary these would be raised with the Deputy Medical Director.
Fife	They can access all services provided by our OHS which includes counselling.
Forth Valley	The staff would report any concerns to the Primary Care Manager/Associate Medical Director where appropriate support would be offered.
Glasgow	We are a small, tight team and our Lead Clinician and Clinical Director offer support particularly following upsetting and difficult engagement, this is also available following disruptive and abusive incidents. We also regularly review our risk assessments, particularly for our most challenging patients.
Clyde	Staff members can speak to the lead GP and Practice Manager regarding any incidents or to raise concerns. Counselling would be available via Occupational Health Services. Police Scotland have a dedicated line for staff to phone to request Police presence.
Highland – Argyll & Bute HSCP	No additional support out with the practice.
Lanarkshire	Salus occupational health service is available to staff, support from line manager is also available.
Lothian	Clinical debriefs prior to all practice sessions with all CBGP staff. Meetings with Clinical Psychologist. Committee meetings - quarterly
Tayside	This would be managed by the Lead Salaried GP who is responsible for the service operated under the 2C arrangement.
Western Isles	None

Question Three: Accessibility

A) What times does your service operate?	
Ayrshire & Arran	12.00pm every Tuesday, with the exception of when the clinician is on annual leave. At all other times a telephone consultation service is available. Messages are left on the answer machine.
Borders	This is expected to be one session per fortnight with the times still to be agreed with the contracting practice.
Dumfries & Galloway	0800 hrs to 1800 hrs Monday to Friday
Fife	5pm to 6pm week night s for appointments. Telephone advice 8am to 6pm week days.
Forth Valley	Monday – Friday 8am – 6pm
Glasgow	Our CBRS Clinic is operational Monday mornings and Thursday mornings from 9.30am to 12 noon. Each clinic is staffed by one CBRS GP and a CBRS Practice Nurse, one member of admin team and 2 security guards at all times.
Clyde	The same time as core general practice hours – 8am to 6pm Monday to Friday.
Highland – Argyll & Bute HSCP	Between the hours of 8am-6pm though this can be amended within the contract agreement between the GP and patient if the practice providing the service does not have their reception open at 8am, for example.
Lanarkshire	Monday evening after 5pm for patients, the associated administration occurs every weekday.
Lothian	Wednesday 11AM – 1PM and Friday 10.30AM – 12.30PM
Tayside	Within core hours 8am to 6pm, although as described above, actual attendance at the surgery is managed to ensure limited exposure to other members of the public.
Western Isles	Appointments arranged In Hours

B) Outside of these times, where can patients receive care? E.g. are they eligible to access out of hours GP?	
Ayrshire & Arran	Accident and Emergency
Borders	Patients will continue to receive care from Out-of-Hours services (with the exception of a home visit) and/or A&E as appropriate.
Dumfries & Galloway	Via the Out of Hours Service the same as all other patients, OOH are notified of all DPCS patients registered with the service.
Fife	At one of our OOH centres.
Forth Valley	OOH Service
Glasgow	Patients are advised to attend their nearest A & E or contact NHS 24.
Clyde	OOH's , NHS 24, Psychiatry Dept, A&E, Scottish Ambulance Service (as well as Police) are advised at time of acceptance onto the CBR register of the patients details.
Highland – Argyll & Bute HSCP	Yes patients can access out of hours out with these times. The NHS Highland and NHSGG&C OOH Hubs are advised when a patient is assigned to the DES and when they are subsequently removed.
Lanarkshire	A&E
Lothian	A&E-arranged by contacting NHS24. All patients are advised of arrangements in writing when they join the service. All patients have a standard KIS that describes these arrangements.
Tayside	As with all patients, access to general medical services in an emergency is available via the OOHs service who are alerted to the patient's inclusion in the scheme as part of the allocation process.
Western Isles	

C) While waiting for their first appointment with your service, where are patients expected to receive care?	
Ayrshire & Arran	Accident and Emergency
Borders	They will continue to receive regular medication from the practice they have been removed from until they have been transferred to the Challenging Behaviour Practice. Telephone appointments are available with the OOH (BECS) and A&E as required.
Dumfries & Galloway	Prior to first planned appointment arrangements would be made, where appropriate, to be seen at the DPCS practice.
Fife	There is usually no delay in them being seen.
Forth Valley	DPCS as the patients are assigned to this service immediately
Glasgow	As above, all newly registered patients are lettered with their first appointment and a copy of our CBRS protocols which state that we are not an emergency service and outwith appointment times, patient should attend their nearest A & E.
Clyde	Patients are deregistered and re-registered at the same time, so no overlap.
Highland – Argyll & Bute HSCP	OOH GP; A&E
Lanarkshire	If the issues can be dealt with via phone then the GP is able to deal with a range of issues, for example if there was a medication issue the GP could prescribe if there was confirmation from previous GP that the patent was on such medication(s).
Lothian	Referring GP Practice or A&E
Tayside	Patients are transferred immediately from removing practice to 2C practice operating scheme. If patients require immediate care then the 2C practice will arrange this with the patient direct.
Western Isles	N/A

D) Do you offer home visits?	
Ayrshire & Arran	No
Borders	No, the patient would be expected to attend clinics.
Dumfries & Galloway	As part of the agreement between the Health Board, practice and patient no home visits are provided.
Fife	No
Forth Valley	Only in exceptionally circumstances
Glasgow	No, we have no facility or budget to offer this, and have only once received a request. Most of our registered CBRS patients are too volatile to allow for home visits.
Clyde	No
Highland – Argyll & Bute HSCP	No. Home visits are not permitted.
Lanarkshire	No
Lothian	No
Tayside	No. Patients advised to attend A&E if they feel that their need can't wait to be seen within the surgery setting at an agreed time.
Western Isles	No

E) What transport arrangements are in place for patients travelling to access your service?	
Ayrshire & Arran	It would be patients responsibility to manage travel arrangement to service
Borders	Patients are expected to make their own way to the clinics.
Dumfries & Galloway	No transport arrangements in place.
Fife	N/A. We do not reimburse travel expenses.
Forth Valley	None. We do not reimburse patient travelling costs.
Glasgow	None – please refer to previous answer. There is no mechanism for patients to claim travel expenses.
Clyde	Nil. There is no mechanism for patients to claim travel expenses.
Highland – Argyll & Bute HSCP	None. Travel expenses not reimbursed.
Lanarkshire	Patients have transport costs reimbursed.
Lothian	Travel expenses reimbursed.
Tayside	Reimbursement of public transport expenses available on request.
Western Isles	None. No travel expenses.

Question Four: Return to Mainstream General Practice

A) What is the average length of time that patients are cared for in your service? Do you have time limits or targets?	
Ayrshire & Arran	Patients should spend no more than 12 months with the service. If there has been no contact with the patient in the first 9 months of their registration they are offered a review visit/assessment prior to discharge but lack of attendance should not be a barrier to them returning to GMS
Borders	It is estimated that the patients will remain within the service for a period of 6 to 12 months. They will be re-evaluated after this period although it is acknowledged there will be some patients that will not be able to return to mainstream services.
Dumfries & Galloway	Most patients do remain part of DPCS unless their circumstances change and it is considered appropriate that they can register with a main stream practice.
Fife	Reviews every six months. Average period 1 year.
Forth Valley	Review patient every 6 months – clinical and risk review to decide if patient require to remain on DPCS Patients should be seen at least once a year No upper duration limit – dependent on individual patient circumstances More wide ranging review every three years – justification for continuance e.g. personality disorders Where required, the DPCS GP can attend the GMS Performance Group to present cases where additional input is required.
Glasgow	There is no average length of time for any patient, it is based upon a patient's ability and capacity to engage and have a desire to return to mainstream GP Practice.
Clyde	Shortest time a patient was on the CBR register was 1 month. Longest patient on CBR register – 10 years (Patients time on the CBR register is greatly influenced by long term prison sentencing). They are taken off the register temporarily whilst in prison. When released they immediately go back onto the register. Our timescales show commencement onto service and when 'stepped off'. Since 2004, the average length of time patient are cared for in the service is 6 years. (Again this figure is skewed by prison sentences). No limits or targets.
Highland – Argyll & Bute HSCP	Patients included in the DES are reviewed at 3 monthly interviews. We do not have a time limit for inclusion or return to mainstream GMS as it depends on each individual patient and how their behaviour is progressing.
Lanarkshire	Some patients have been in the clinic for a number of years, there are no available data on this.
Lothian	No time limits. Target to return the patient to mainstream GP services as soon as possible.

Tayside	There are no time limits or targets. Assessment is made by the Lead Salaried GP at the 2C practice. If she feels that the patient has reached a stage that they may be considered for mainstreaming then the Health Board seek advice from any other parties, e.g KeepWell Nurses, who may have been indirectly or directly involved in the patient's care before the HSCP Clinical Lead, Associate Medical Director, Primary Care, an GP Sub Committee are asked to consider and decide on appropriateness of mainstreaming based on information received.
Western Isles	1 Year; half-yearly reviews

B) How does your service attempt to address the underlying issues that led to a patients referral?	
Ayrshire & Arran	We explore the issues which led them to become involved with the service and treat those conditions that are amenable to such
Borders	By identifying the cause of the underlying behaviour & referring to the most appropriate place such as mental health & addition services.
Dumfries & Galloway	Often minor disgruntlement in patients with poor coping skills that simply need handling differently.
Fife	This is done opportunistically at consultations.
Forth Valley	Each patient should have an action plan including medicine review completed at least annually
Glasgow	Every newly registered patient is referred to our Team at Forensic Psychology following their 1st GP appointment, this is for a baseline assessment, and this 2 hour appointment is to assess the reason behind the disruptive behaviour which led to referral to CBRS.
Clyde	Patient comes onto the service on status of 'Full' where Police presence is required. Once the GP and panel agree that there is more effective engagement with appropriate interaction from patient and further evaluation has taken place, meriting de-scaling, they go onto 'Step Down' – where no Police presence is required.
Highland – Argyll & Bute HSCP	The GP Practice should be taking steps to rehabilitate the patient to allow the patient to return to mainstream GMS when appropriate. This is part of the DES.
Lanarkshire	Substance misuse and anger management are common issues for referral, patients are referred to relevant services specific to their individual needs.
Lothian	Patients challenging behaviour and its cause is addressed in appointments. Referrals to Psychology or Specialist Services as required.
Tayside	As with all patients, access to Drug and Alcohol Abuse clinics is available, along with direction to associated services.
Western Isles	Left with practice

C) What, if any, steps are taken by your service to rehabilitate patients into mainstream general practice?	
Ayrshire & Arran	At each appointment reference is made to the patient's pending return to GMS and how they might better relate to mainstream services.
Borders	These are still to be established.
Dumfries & Galloway	Nothing really. Patients often settle in well at the practice although some (minority) have drug seeking behaviour.
Fife	Nothing specific.
Forth Valley	If review suggests that patients can be returned to mainstream practice this is supported
Glasgow	As above, our Lead Clinician is in regular contact with Forensic Psychology to request further assessments where needed.
Clyde	Refer to note above. Quarterly review meetings on each case are discussed and consensus reached on whether patient should remain on 'Full', 'Step Down', or 'Step Off' status.
Highland – Argyll & Bute HSCP	As above.
Lanarkshire	Patients are able to access a range of services such as counselling etc., the GP who provides the CPS clinic would determine if a patient was stable to return to mainstream general practice.
Lothian	Target is to return patients to mainstream GP. Patients regularly reassessed. Patients are offered the opportunity to address circumstances: medical, social or relational that contributed to their challenging behaviour.
Tayside	Patients may be placed on a 'Behavioural Contract' which is regularly reviewed by the 2C practice in conjunction with the patient concerned.
Western Isles	None

D) How do you determine a patients' readiness to return to mainstream general practice?	
Ayrshire & Arran	They are assessed over several appointments and the reason for their being referred explored. The return advice is multifactorial but currently sits with an experienced clinician. There is no psychology or psychiatric opinion sought or available.
Borders	This will be evaluated by the Patient Risk Panel.
Dumfries & Galloway	Once they interact with services normally, they are stable within approximately one year.
Fife	GPs running the service are asked to make this decision at the six monthly review.
Forth Valley	The patients are reviewed every 6 months
Glasgow	Please see above answer, prior to return to mainstream practice, our clinical panel discuss patient's suitability for discharge and patient is again seen by colleagues at Forensic Psychology for a discharge assessment. The results of which are then discussed by the clinical panel and patient is advised accordingly.
Clyde	See above.
Highland – Argyll & Bute HSCP	The DES GP completes a review form to allow the review panel (Associate Medical Director, Locality Clinical Lead and Primary Care Manager) to consider whether it is appropriate to agree that the patient can return to mainstream GMS.
Lanarkshire	This will be specific to individual patients, the GP who provides the CPS clinic uses their clinical judgment on a case by case basis.
Lothian	Team assessment of their behaviour and consideration of whether their needs will be met within the current mainstream GP offering.
Tayside	As described above.
Western Isles	Left with practice

E) Are patients able to return to their previous practice?	
Ayrshire & Arran	Our protocol dictates that when the patient is reviewed and deemed suitable for discharge where possible we do not allocate the patient to the original referring practice. However due to the geographical nature or Ayrshire & Arran, on occasion the patient will return to their original practice as this is the only practice that covers the patients home address. However there is considerable resistance to this.
Borders	Yes, if this is deemed appropriate. Due to the rural nature of the Health Board there is often only one GP practice covering a geographical area.
Dumfries & Galloway	Yes as long as their practice list is open and they have continued to live in that catchment area.
Fife	No but they will be allocated to a practice local to them when they are discharged.
Forth Valley	No (only in exceptional circumstances eg remote / rural practices)
Glasgow	Very rarely, if at all does the patient return to their previous practice. More often, patient has moved home since engagement and referral to CBRS. The new mainstream GP is determined by the patient postcode and discussion is agreed with our clinical panel and PSD.
Clyde	No, however in smaller more rural practices they may have to return to their own practice but generally they would seek a different medical practice.
Highland – Argyll & Bute HSCP	The geography of Argyll and Bute means that in the majority of cases the patient has to return to their previous practice.
Lanarkshire	This would be dependent on the original reasons for removal, in general it is unlikely this would be the case.
Lothian	Yes unless there has been an extreme serious event leading to the referral, in which case an alternative practice is approached.
Tayside	If the patient wishes, the Associate Medical Director, Primary Care will consult with the previous practice but more often than not, given the circumstances of removal, the practice is extremely reluctant, or refuses to have the patient back. However, once patients have been deemed to be able to move back into the community, they are encouraged to register with a practice of their choice or, if experiencing difficulty, to seek allocation via PSD.
Western Isles	Occasionally

F) How is the handover process to the receiving practice managed/facilitated?	
Ayrshire & Arran	Once the patient has been reviewed by the CBS Team GP the GP will advise the patient of his intention to discharge the patient from the service. Following this a Review report is completed by the GP and forwarded to the Primary Care Management Team, who then contact PSD Registration Team to be advised of which practice the patient can be allocated to. Once this process is completed PSD Registration issue a letter to the patient confirming their discharge from the CBS and confirm practice allocation. The receiving practice is also contacted by the Primary Care Management Team and advised of the pending allocation to them of this patient and the CBS review report is shared with them at this time.
Borders	There will be a 3 month trial period in which the patient can attend mainstream services. Feedback will be provided to the contracted practice & if any issues arise the patient may return to the Challenging Behaviour Practice (should the Patient Risk Panel agree).
Dumfries & Galloway	The practice require to have the Health Board's agreement before a patient is transferred back into a main stream practice. If agreed the practice will notify the agreement to the patient at their next appointment and this will be supported with a letter from the Board to the patient. If the patient falls within the practice area of the DPCS practice they may remain with the practice. If outwith the practice boundary they will be given the options available to them. A notification is sent to all GP practices and the Out of Hours Service to notify them that the patient is no longer part of the DPCS. There is no formal handover process, as patient is now considered mainstream GMS patient however the DPCS GP Lead would be happy to speak to receiving practice GP if requested.
Fife	By the Service GP and the new GP liaising.
Forth Valley	By Primary Care Contractor Services
Glasgow	All of our records are electronic. We use EMIS and Docman and once patient is referred to mainstream GP, Practice Manager letters PSD with a request to deduct patient from CBRS and align to new GP Practice. PSD will then electronically deduct patient's records and these are assigned to new mainstream GP.
Clyde	The patient receives their letter at the same time as other patients who have moved practice from PSD. Paper records are transferred as soon as they are received and docman transferred, timescale dependant on removing GP
Highland – Argyll & Bute HSCP	We do not generally require a specific handover process.
Lanarkshire	This is a clinician to clinician discussion, there can also be other services involved e.g. MAPPA and there would be liaison with a practice in such circumstances.

Lothian	A risk assessment is completed. Patients are supported through discussion to know what to expect. Behaviour contracts are sometimes used to support this. Information about the patients is shared with receiving practices when required. Administration team support and deal directly with mainstream practice.
Tayside	In all instances, PSD inform the Associate Medical Director, Primary Care of the practice who have accepted registration in order that she may contact the senior partner or Practice Manager, to offer background to the patient. The Lead Salaried GP from the 2C practice is also asked to provide any relevant information to the practice based on their experience of the patient whist registered with them under the scheme.
Western Isles	As practices provide the service, usually after being removed from the Violent Patient list, patients continue staying with the practice

G) Is any ongoing monitoring or support provided for the receiving practice?	
	Advice is given re behavioural contracts – nil else formal.
Borders	The 3 month trial period will apply & any additional requirements can be addressed by contacting the Associate Medical Director.
Dumfries & Galloway	No ongoing monitoring, the practice would make contact with the Board if any concerns, support would be available if required.
Fife	No
Forth Valley	Assignment will be for an initial period of six months with the intention that the patient will remain with the practice Both the GP practice and the patient will be notified of the assignment arrangements. If a patient is challenging to manage during this period – the practice should contact PCCS – a further communication will be sent to remind the patient of the possible return to the DPCS. Where a patient demonstrates further episodes of violence and aggression which give cause for concern – patient can be re assigned to the Direct Patient Care Service.
Glasgow	Yes, our Lead Clinician can be contacted by the new receiving practice if needed.
Clyde	No
Highland – Argyll & Bute HSCP	No
Lanarkshire	No
Lothian	Yes- practices are encouraged to contact CBGP if there are any issues that arise when patient returns to mainstream practice, with the offer that patients can be 'taken back' quickly if required.
Tayside	Not directly.
Western Isles	

Question Five: Service evaluation

A) What data do you routinely collect about any aspect of your service?	
Ayrshire & Arran	Current Patient numbers only
Borders	None to date. Will aim to monitor the number of violent instances while in the care of the service, length of care, patient numbers etc.
Dumfries & Galloway	Number of patients currently accessing care via DPCS.
Fife	We have an annual review with the practice.
Forth Valley	None
Glasgow	We also utilise GP EMIS to collate data on attendance and issue D.N.A. (did not attend) letters to patients who do not keep their appointments. GP EMIS and Docman allow us to receive electronic documents for any patients who attend any A & E departments and this is also recorded on patients electronic records. For severely disruptive patients, and we have a few, we also collect data on the frequency of their calls to CBRS together with the abusive language and disruption they cause.
Clyde	Overview of patient attendance done quarterly for discussion at CBR meetings. This involves who is on the scheme; the length of time on the scheme and how many consultations there has been (including telephone consultations).
Highland – Argyll & Bute HSCP	None
Lanarkshire	Patients registered at the CPS clinic Costs associated with provision of the service
Lothian	Number of appointments Number of patients
Tayside	The 2C practice is required to provide the Health Board with regular updates, however, there tends to be little information forthcoming until such time as the practice feels that a patient may be ready to be mainstreamed.
Western Isles	Only activity data

B) Do you collect any data on subsequent violent behaviour in primary care?	
Ayrshire & Arran	No
Borders	No, we would anticipate further violent occurrences would mean the patient returns to the Challenging Behaviour Practice & therefore data would be collected.
Dumfries & Galloway	The Primary Care team manage this service for the Board and would be made aware of any subsequent violent behaviour, annual reviews are undertaken by the DPCS practice to also capture this information and these reviews are considered by the Board.
Fife	Not currently.
Forth Valley	No
Glasgow	Yes – we carry out additional Risk assessments when a CBRS patient causes an incident and record this on our own incident reporting system – Datix.
Clyde	No
Highland – Argyll & Bute HSCP	No
Lanarkshire	No
Lothian	No
Tayside	No
Western Isles	No

C) How do you evaluate your service?	
Ayrshire & Arran	Ongoing monitoring and team discussions, returns to service are scrutinised and discussed amongst the team
Borders	This is still to be established.
Dumfries & Galloway	Annual review is undertaken and a summary of this is provided to the Medical Director who is asked to consider and approve the continued provision of care.
Fife	As above - we have an annual review with the practice.
Forth Valley	The DPCS Practice Criteria was reviewed 2017
Glasgow	We carry out an annual review and letter patients who have not attended or engaged with us for 12 months. Often, the reason for non engagement is due to patients being incarcerated with HMP for prolonged periods of time.
Clyde	There is no formal evaluation.
Highland – Argyll & Bute HSCP	Not required as the number of assignments to the DES are minimal.
Lanarkshire	There have been periodic reviews on the service
Lothian	This is not done
Tayside	No
Western Isles	Laissez faire – monitoring complaints

D) Have you undertaken any audits of your service? If so, please provide details and indicate whether you would be willing to share this data.	
Ayrshire & Arran	On an annual basis we review the patient numbers on the service and run a report highlighting patients who have remained on the service for more than 12 months, and the CBS GP will take a view on whether these patients are now suitable for discharge or require a further 3/ 6 months with the service before consideration for review again.
Borders	No
Dumfries & Galloway	No
Fife	No
Forth Valley	No
Glasgow	Yes, as above, we carry out an annual clinical governance review. We also, annually carry out and publish an Annual Report – this has not yet been submitted this year to increased volume of new patients and several disruptive and violent incidents, whereby Police intervention has been necessary.
Clyde	No
Highland – Argyll & Bute HSCP	No
Lanarkshire	No specific audits have been undertaken.
Lothian	No
Tayside	No
Western Isles	No

E) Have you evaluated the patient experience of your service? Please provide details.	
Ayrshire & Arran	We do not currently do this but it may be useful to offer a patient survey to patients when they leave the service?
Borders	No
Dumfries & Galloway	No
Fife	No
Forth Valley	No
Glasgow	We did previously, but have not carried this out for approx. 14 months.
Clyde	No however this is something we would consider.
Highland – Argyll & Bute HSCP	No
Lanarkshire	The Health and Care Experience Surveys are open to registered patients, during the last survey over 130,000 people responded, we do consider the results of this survey.
Lothian	We have not done this
Tayside	No
Western Isles	No

Question Six: Challenges encountered

A) What are the main challenges your service faces?	
Ayrshire & Arran	Risk to staff safety at clinic due to no police presence.
Borders	One main challenge so far has been location in terms of meeting safe room regulations – both are in a central location. The other is engaging with a practice that is willing to take on the service.
Dumfries & Galloway	One or two drug seeking patients who live out with the practice area.
Fife	Number of referrals at the highest they have ever been. The practice providing the service is threatening to resign from the LES due to this and we are concerned no one else will pick it up.
Forth Valley	Sustainability- Have required to contract with new providers on a number of occasions. Ongoing patient behaviours particularly verbal abuse
Glasgow	- Patients' reluctance to accept that their own abusive and unruly behaviour was sufficient for them to be assigned to CBRS. - Unwillingness to attend and constant abusive phone calls to advise why. - Access to this service, given that CBRS has tripled in size this year with a plethora of new patients. - Constant swearing and threatening phone calls from newly registered patients who do not want to engage with us. - Constant verbal complaints from some patients who feel they should be prescribed opiates and controlled drugs. - Refusal to follow protocols and patients arriving at other HSC P sites causing distress and disruption to services, even though they have been engaging at our current site. - No notification from HMP when patient is incarcerated, and only brief information received when they are liberated.
Clyde	No additional support outside of the Police. Training for staff. A secondary challenge is the turnaround time for panel members to review a new referral. We have a process in place for absences and holiday periods – see below: Decision from receiving a VPR form has to be within 48 hours. If patient taken off the practice register and not accepted onto scheme then they either go back onto the same practice or they can find a practice on their own and/or be noted as a temporary resident.

	If the decision cannot be agreed within the panel within the 48 hours, then the default position is that we accept the patient onto the Violent Patient register which can later be revoked, if need be, following lengthier discussion. If Chair on annual leave or unavailable then the GP from alternative area from where the patient is resident has the definitive decision e.g. Inverclyde or Renfrewshire. The decision will be based on the majority, however if more than 50% agree then this will stand.
Highland – Argyll & Bute HSCP	- Remote and rural. - Interim DES arrangements being made with the same practice that removed the violent patient - Police non-engagement ,on occasion - Police availability to attend appointments
Lanarkshire	Variation in dealing with different agencies, prisons, lawyers etc. Dealing with abusive patients.
Lothian	Increasing number of angry patients. Expectation of referring practices that extremely violent patients will be accepted. Expectation of referring GPs that all referrals will be accepted. Awareness of referring practices that there are steps that they can take with the patients prior to referrals eg Behavioural contracts. Safety of administration team in reception area-registration desk is not fit for purpose. Mismatch between GP duty of care to protect staff from harm/ provide safe working environment and patient need.
Tayside	The inability to engage with clinicians willing to support the Health Board to operated the scheme.
Western Isles	In Lewis & Harris, unwillingness of practices to participate in the DES

B) If you have received complaints about your service, please provide details about the broad nature of these.	
Ayrshire & Arran	Some patients unhappy being unable to access the Practice in the same manner they would in a regular GP Practice. Contact only via answering machine. Patient cannot make immediate contact and time frame maximum 48 hours for action on any queries
Borders	N/A
Dumfries & Galloway	No complaints received
Fife	None. One or two teething problems with new patients and medication but usually sorted out in 24 hours.
Forth Valley	None that I am aware of
Glasgow	We've only received 3 complaints this year about the Service. Rrefusal to accept their behaviour has led them to be registered with CBRS.
Clyde	No formal complaints have been received about the service.
Highland – Argyll & Bute HSCP	No
Lanarkshire	Most complaints are about having to attend the CPS clinic in the first place. Patients also complain about the limited opening time of the CPS clinic.
Lothian	Yes. Complaints are taken by the Patient Experience Team – generally about medication not been prescribed at the patients request as the GP and CPN do not believe it is in the patients best interest. A number of patients see the care arrangements as a breach of their human rights. One patient complained that he had not been offered routine care of a long term condition.
Tayside	Scheme operates from 2C practice in Dundee only resulting in patients from Perth being required to travel to Dundee to access services.
Western Isles	

Question Seven: Broader perspectives on challenging behaviour services

A) Why do you think some patients are violent in GP settings?	
Ayrshire & Arran	Frustration in obtaining appointments GP Practice not meeting patients expectation of what the GP can provide for them Drug and Alcohol Misuse Mental Health Crisis
Borders	From the patient contacts we have experienced it can be for a number of reasons including (but not exclusively): - Frustrated at a clinical/healthcare professional not prescribing drugs that the patient is looking for; - Frustrated that the clinician/healthcare professional is not giving the specific care that the patient wants; - Viewing the clinician as another member of the establishment/government & has a pre-set agenda to cause disruption; - Either not understanding or willing to believe their diagnosis/situation.
Dumfries & Galloway	All about how patient is handled ie no point in making patients wait for prescriptions/refuse sick lines when clearly its required.
Fife	Some have drug dependencies and are unhappy if they are not prescribed the drugs they are requesting. This is our most common reason for violence.
Glasgow	Largely personality disorder, alcohol/drug addiction or mental health issues, or patient's threatening GP staff when drug seeking.
Forth Valley	Multi-factorial and relates to behaviours in other settings
Clyde	Unreasonable expectations by the patient. Poor interaction and social skills, coupled with an addiction whether it is alcohol or drug related.
Highland – Argyll & Bute HSCP	Patients: - Not getting the medication they want - Breakdown of GP/Patient relationship
Lanarkshire	Challenging behaviour has a variety of causes, including illness. Common issues related to patient behaviour can be linked to substance misuse, intoxication etc. Some patients may also have mental health issues in addition to a physical problems.
Lothian	They feel they are not being listened to or getting their needs met. They feel let down.

	Most patients have complex psycho-social needs. Lack of services to meet needs of patients with complex problems- eg lack of Personality Disorder service. Lack of service for provision of addiction services in secure setting.
Tayside	Drug and alcohol abusers who are in a general violent and aggressive state – particularly when seeking medication.
Western Isles	Frustration at not getting their way

B) What sort of patients are typically violent?	
Ayrshire & Arran	Many of our patients have chaotic lifestyles and due to this have limited access to support, resulting in undiagnosed mental health issues and increased substance misuse.
Borders	Those with mental health & addictive conditions.
Dumfries & Galloway	Drug users/ex prison. Physical violence very minimal more verbally violent.
Fife	Those with either drug dependencies or mental health problems.
Forth Valley	Patients with metal health and particularly forensic and substance issues
Glasgow	See above – both male and female patients fit this category. From 01/04/2014, there have been a total of 22 female patients assigned to the CBRS Clinic, and a total of 321 male patients assigned to CBRS Clinic.
Clyde	As above and generally fall into the category of young males 20 – 30.
Highland – Argyll & Bute HSCP	Patients with: - Mental Health issues - Addiction issues - Anger management issues
Lanarkshire	The majority of patients in the CPS service are male, aged between 22 – 54 years of age.
Lothian	Patients with low relational capital. Patients who feel powerless. Patients who interact with services when they are intoxicated. Patients whose needs are not met by existing services. Patients with anger and/or multiple trauma history or complex PTSD.
Tayside	Drug and alcohol abusers.
Western Isles	Substance abuse – patients are often “known” – small communities

C) What do you think the role of your service is?	
Ayrshire & Arran	To provide General Medical Services to patients who are unsuitable for mainstream GMS Practice with a view to providing support and ongoing referral to appropriate services for the patient until they are able to return to and integrate back into mainstream primary care. We enable, understand, de-escalate and provide treatment in a secure environment.
Borders	To provide a well organised/safe space to enable clinicians to provide primary medical services to patients that are unable to engage with mainstream services.
Dumfries & Galloway	Make the patient realise the world and medical services are not against them. Patient safety, and safety of the practice team.
Fife	To provide GMS without prejudice to patients unsafe to be seen in a routine general practice environment.
Forth Valley	Provision of GMS particularly prescribing and support for lifestyle change
Glasgow	To rehabilitate patients in a place of trust, easy to access and a place of safety – with additional referral to services which the individual patient may need access to.
Clyde	To be able to provide a service to the patient in a safe setting, and in a controlled environment. At all times, ensuring the protection of the GP, workforce and patients.
Highland – Argyll & Bute HSCP	Rehabilitation of patients.
Lanarkshire	The CPS clinic is provided under the Primary Medical Services (Directed Enhanced Services) (Scotland) Directions, these Directions place a legal obligation on NHS Boards to provide primary medical services to patients who have been removed from their mainstream GP practice, primarily because of violence/aggression.
Lothian	To offer primary care services to patients who can not be managed within the mainstream GP service. Rehabilitation of patient into mainstream GP services.
Tayside	To ensure safe, adequate access to general medical services and to aim to rehabilitate patients into society where possible.
Western Isles	To provide access to General Medical Services

D) What does your service try to achieve?	
Ayrshire & Arran	Our service tries to provide the highest quality of primary care within a safe and secure environment to patients unsuitable for General Medical Services.
Borders	The service is trying to establish the underlying reason that the patient is not able to cope within mainstream services & develop a plan for them to return.
Dumfries & Galloway	Make the person feel treated normally with respect whatever is wrong and not label patient as a trouble maker.
Fife	Good care, and rehabilitation.
Forth Valley	Ongoing access to GMS . Protection of primary care workforce
Glasgow	Rehabilitation back to mainstream GP Practice, and addressing issues patient presents with – anger issues; abandonment issues; drug seeking behaviour; criminal activity; personality disorder.
Clyde	We try to achieve rehabilitation of the patient back into standard GMS service.
Highland – Argyll & Bute HSCP	Successful rehabilitation of patients. Safer environment for Practice staff and GPs
Lanarkshire	The service tries to achieve meeting the requirements as set out in the Primary Medical Services (Directed Enhanced Services) (Scotland) Directions.
Lothian	To provide care / more time / understanding to patients with complex and difficult to manage needs.
Tayside	A safe and secure environment for patient to be seen and where their service needs can be addressed.
Western Isles	To provide access to General Medical Services

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-80004-211-7 (web only)

Published by The Scottish Government, October 2020

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS778706 (10/20)