

Tackling nuisance and disturbance behaviour on NHS healthcare premises

**Report on consultation
October 2006**

Summary

1. In June 2006, the Department of Health published a consultation paper, Tackling nuisance and disturbance behaviour on NHS healthcare premises: a paper for consultation. The consultation period ended on 1 September 2006 and produced over 150 responses. The Department is grateful to those who responded to the consultation exercise.
2. The draft proposals cover
 - the creation of a new offence of causing a nuisance or disturbance on NHS healthcare premises
 - a power for certain NHS employees to remove individuals causing a nuisance or disturbance
 - safeguards to protect individuals, particularly those who are vulnerable.
3. Around 500 copies of the consultation paper were distributed and it was also published on the Department of Health's consultations website. In addition, a pre-launch consultation event was held to which representatives from NHS health bodies and other interested parties were invited. The idea of the event was to raise awareness of the consultation, stimulate debate and to encourage NHS health bodies to hold their own events with staff and patients.
4. This document provides a summary evaluation of the numerical data and comments received in response to the consultation. It discusses the main points arising from the responses received and indicates their impact on the proposals.

Introduction

5. Incidents of nuisance and disturbance can have a negative impact on the delivery of healthcare within the NHS and may contribute to an environment in which staff and patients feel less secure. These proposals were developed within the context of the Government's Respect Programme which focuses on the need for two-way respect between workers serving the public and the individuals and communities to whom they provide a service.

Responses

6. The consultation produced 158 responses. Organisations responding included NHS bodies, professional associations, Royal Colleges, statutory regulatory bodies, patient representative bodies and service user representative groups. Responses were also received from individual members of the public and members of NHS staff. Please see list attached at Annex A.
7. The consultation document posed a series of questions and responses are discussed below in relation to each of these. The paper also asked for general comments and some respondents chose not to respond specifically to the questions posed but raised issues that will also be addressed where relevant.

Conclusion

8. Overall, the majority of respondents supported the proposals. There was widespread recognition of the problem that nuisance and disturbance behaviour causes for NHS health bodies. There was general agreement that a new offence was needed to tackle this sort of behaviour and a formalised process for the removal of these individuals was welcomed.

9. While most respondents felt that the proposals were more relevant to the acute setting, it was also recognised that there were some examples of nuisance and disturbance in other settings. However, the lack of suitably trained security staff, particularly in primary care and mental health settings, was highlighted by many respondents as a potential issue. Other areas of substantial debate and discussion were the potential impact on those with mental health problems or other conditions affecting their behaviour and the safeguards that could be implemented.

Summary of responses

New legislation and what it might cover: offence of nuisance or disturbance behaviour on NHS healthcare premises and a power to remove such individuals from NHS healthcare premises

Question 1: Do you agree that a new offence and power of removal is needed to deal with the problem of nuisance and disturbance behaviour on NHS premises?

1.1 Over three-quarters (78%) of those respondents who expressed a view agreed that a new offence and power of removal was needed and 22% did not agree. Amongst those supporting the proposals, it was generally agreed that this sort of behaviour impacts on the delivery of healthcare and is frustrating and sometimes threatening for staff and patients.

1.2 Many respondents felt there was a clear gap in the current legislative arrangements and welcomed a more robust and workable process which sets out clear consequences for causing a nuisance or disturbance. Respondents felt that new legislation would remove current ambiguities in the law and empower health bodies to tackle the problem. This in turn would send out a clear deterrent message to potential offenders.

1.3 Amongst those who were opposed to the proposal, a minority of respondents felt that existing legislation was adequate to deal with the problem. Several respondents were concerned at the lack of available data on the numbers of incidents of nuisance and disturbance behaviour and wanted to see more evidence for the need for further legislation. Groups representing service users were concerned about the potential for misuse and highlighted the need to address reasons for any such behaviour rather than criminalising these individuals. This was also raised by several respondents who nevertheless supported the proposals with appropriate safeguards. Finally,

several respondents were concerned about the lack of suitably trained security staff to exercise the power of removal. Again, this point was also made by several respondents who supported the proposals, who referred to the difficulties of implementation where a trust is based on multiple sites or in community settings.

1.4 The Department is carefully considering all the points raised. The lack of data on the numbers of incidents is acknowledged but the consultation process has produced further information on this, indicating that there is a clear need for the legislation. The Department understands the concerns about the potential for misuse and is undertaking further work to address this issue. For example, the development of guidance and a training programme are under consideration.

Question 2: Do you agree that s. 547 of the Education Act 1996 is a suitable model?

2.1 Again, around three quarters of those respondents (75%) who expressed a view agreed that this was a suitable model for use. Twenty-one per cent disagreed and 4% said that they would like more information before making this decision.

2.2 Two main reasons were given by those who did not agree that it was a suitable model. Some respondents disapproved as there was no evidence that it had worked in schools. Other respondents pointed out the differences between schools and NHS premises. Any legislation introduced will recognise this fact and will be drafted to account for this.

Question 3: Which types of behaviour should be covered?

3.1 There was general agreement that the examples given in the consultation document should be covered by the new offence. Large numbers of respondents wanted to ensure that the offence covered behaviour which interferes with the rights of others to use health service facilities, by interrupting or preventing patient care. Responses from NHS health bodies, individual staff members and patients referred to behaviour which is not only disruptive to the health service but also compromises the dignity and respect of others. They also described behaviour which can be intimidating to patients, staff or other visitors and can be threatening and potentially dangerous.

3.2 Specific behaviours mentioned included the following:

- patients or their relatives causing a nuisance by verbal aggression
- habitual attendees who visit Emergency Department who do not require treatment
- visitors who refuse to abide by Trust rules
- foul language
- spitting
- defecating/urinating

- excessive noise
- offensive behaviour including sexual gestures, behaviour or remarks
- obstructing thoroughfares
- drinking alcohol on the premises.

3.3 A few respondents raised concerns about this aspect of the proposals and the subjective nature of the term ‘nuisance or disturbance’. However, whilst some respondents wanted a clear definition, others said that the legislation should not contain a prescriptive list.

3.4 The main issue commented on by respondents was that certain behaviour that is perceived to be a nuisance or disturbance may be caused by mental health problems or other conditions affecting the patient. Respondents were concerned to ensure that the legislation is sensitive to this and this is well recognised by the Department. These issues are also dealt with later in this document.

Question 4: Which types of NHS bodies and premises?

4.1 Whilst many respondents agreed with the definition provided, where respondents wanted to see a change to what was stated in the consultation document, it was usually to extend the proposals to cover a wider range of premises. Of those suggesting a change, most respondents wanted to see a broader definition along the lines of “any place providing a clinical service” or “where NHS services are provided”. A consistent theme was the desire to ensure that all staff were protected equally and that the legislation should reflect the trend towards community based settings.

4.2 However, other respondents recognised that it would be difficult for PCTs to act for independent contractors on their own premises. There would also be difficulty in providing a ‘responsible person’ in buildings and sites where there is shared occupation and some of the services are not health based. Other issues raised were the need for suitably trained security staff which are less likely to be available in primary care settings and the need for the implementation to be cost effective; it was also suggested that this type of behaviour is more prevalent in acute settings. For these reasons and the difficulties in extending the legislation and associated powers to privately managed premises, the policy will not be expanded to cover a wider range of premises.

Question 5: Is the proposed sanction appropriate and proportionate?

5.1 Only 40 respondents expressed a view in relation to this question but 88% of these agreed that the sanction was appropriate and proportionate.

5.2 Where respondents disagreed, they generally wanted to see harsher penalties. Several respondents thought that that any fines should be backed up by the option of custodial sentence, in recognition of the fact that the offence had taken place on NHS premises and to provide an effective

deterrent effect. One respondent thought that the proposed method of sanction was cumbersome and time-consuming and the RCN suggested the use of Fixed Penalty Notices as a method of disposal.

5.3 As stated, the majority of respondents agreed with the proposed sanction. However, several of these respondents also expressed concern that the sanction would not be a sufficient deterrent for persistent offenders.

Authorising and exercising the power of removal

Question 6: Do you agree that use of the powers should be authorised by a 'responsible person' designated by the chief executive of the health body?

6.1 Whilst a small number of respondents thought that the implementation of the legislation should be mandatory for health bodies, it was generally agreed that health bodies should be able to decide whether they nominated a 'responsible person' to take this forward. It was widely recognised that this person needs to be suitably trained and agreed that the LSMS would be an appropriate person with the proviso that others would also be able to fulfil the role to ensure cover on all sites and at all times. One respondent suggested that they would need up to 6 'responsible persons' at their trust. Most respondents thought that whoever was nominated should be sufficiently senior and slightly removed from the incident to provide adequate safeguards. Suggestions included the senior staff member in A&E, senior manager on duty, senior clinician on duty, or all executive directors.

6.2 However, a minority of respondents expressed the view that those staff members carrying out the removal should be given the authority to act as 'responsible persons'. One respondent felt that the authority to remove has to be delegated to the individual who will be ultimately exercising that power so that they are able to account for their actions.

6.3 Other views expressed here stated that they would prefer to see the police carrying out the power of removal in all situations, rather than security staff authorised by the 'responsible person'. Reasons for this view included the lack of suitably trained security staff, the increased workload for security staff, the greater powers of the police (e.g. power to request name and address) and the greater deterrent effect.

6.4 The points raised have been noted and any legislation will be drafted to ensure sufficient flexibility to allow for sufficient numbers of 'responsible persons' to be authorised.

Question 7: What additional safeguards do you think will need to be put in place to ensure that these powers are operated in a fair, objective and ethical manner?

7.1 Understandably, this aspect of the proposals prompted extended debate. A wide range of safeguards were suggested in response to this

question but largely fell into one of four categories: guidance on use of the legislation, training for staff implementing the legislation, strict monitoring requirements and consultation with a medical practitioner.

7.2 Respondents felt that guidance was needed on various subjects including physical intervention and the escalation policy. Some respondents wanted to see an agreed protocol so that staff, patients and the public are aware of the actions that may be taken in these circumstances, possibly set out in guidance. One respondent thought that a checklist of procedures would be useful for staff wishing to use the legislation.

7.3 Several respondents mentioned training specifically for the 'responsible person' and more generally for all staff, to ensure consistency in the application of the legislation. Diversity training was considered to be particularly important, as was training on communication skills, emphasising the importance of staff treating patients and the public with courtesy and respect. The HSE stated that the training for the 'responsible person' would need to be adequate as set out in health and safety legislation.

7.4 A large number of respondents discussed monitoring arrangements, suggesting that recording and reporting requirements were key to ensuring appropriate use of the legislation. One respondent called for appropriate paperwork for signature by the 'responsible person' and corroboration by the ward/department senior member of staff on duty. Other respondents wanted to see periodic reviews of incidents requiring removal.

7.5 It was generally agreed that consultation with a medical practitioner was essential in certain circumstances, as outlined in the consultation document. However, a few respondents thought that the requirement should encompass the modernisation of roles within the NHS and should include nurse practitioners and nurse consultants who have the same admitting, discharge and prescribing rights as consultants. Several respondents thought that, particularly in relation to patients with mental health needs, a consultant psychiatrist or other mental health professional should be consulted. Rethink also suggested that the patient's carer should be consulted where possible.

7.6 Other comments referred to signage in appropriate languages, access to a translation system and restrictions of the decision making process to senior staff. One respondent thought that the only way to prevent misuse of the power was to make it an offence to use the powers unreasonably.

7.7 A minority of respondents who were opposed to the proposals thought that no safeguards would be adequate. Concerns raised at this point were the burden of extra training, the risk of injury to staff and patients in carrying out a removal and the risk to the health body of complaints and litigation arising from the use of the power of removal.

7.8 The Department recognises the importance of safeguards in this process. These suggestions will feed into the future development of robust guidance and a comprehensive training programme.

Question 8: What sort of training do you think security staff removing nuisance individuals will need?

8.1 Most respondents mentioned training in physical intervention techniques. Also considered important were conflict resolution training (CRT), equality and diversity training and mental health awareness training.

8.2 Other respondents thought that security staff should have training on the legislation itself and the policy and process, as well as wider training on the law, including statement taking and evidence gathering. One respondent thought the training should meet the SIA licensing requirements, whilst another thought that security staff should receive the same training as that given to the police. Finally one respondent suggested that security staff would benefit from first aid training.

8.3 Several respondents mentioned the need for refresher training, especially in relation to physical intervention and CRT.

8.4 Again, the concerns about the lack of available security staff were raised, as was the cost of training, and the desire to see the police carrying out removal of people from the premises.

8.5 The Mental Health Foundation objected to the reference in the consultation document to the NHS SMS Promoting Safer and Therapeutic Services syllabus and the guidance on physical intervention techniques to be published by the National Institute for Mental Health in England (NIMHE). They suggested that these were inappropriate models for use in these circumstances as they were developed for a different set of circumstances. The Department continues to believe that aspects will be suitable as part of wider training. All other suggestions will be carefully considered.

Question 9: How often do you think the power of removal will be used?

9.1 Most respondents agreed that the power of removal was more relevant for acute trusts, but even within this category responses varied from just a few times a year up to daily for a large inner city trust. There was a peak in responses around use of the power on a weekly basis. However, most agreed that they would expect this to decrease once its deterrent effect was felt.

9.2 The general consensus was that the power would be used very rarely in PCTs, partly due to the lack of security staff.

9.3 Again, it was felt that the power would be used quite rarely in mental health trusts. However, the existence of legislation would provide a powerful backing to staff dealing with incidents.

9.4 Across all responses, there was general agreement that the frequency of use would vary greatly by trust, but the importance of good monitoring arrangements for when it was used was stressed.

Impact of use of the power of removal

Question 10: Do you think these proposals could adversely affect any particular group of society?

10.1 This section did not result in a large number of responses – generally those responding were from organisations representing service users such as Mind, Mencap and the National Autistic Society etc.

10.2 Other respondents generally stated that it was necessary to be aware of the potential for discrimination, but felt that adequate safeguards would prevent this. Again, the importance of monitoring requirements was emphasised by respondents.

10.3 Where concerns were expressed, the vast majority centred around mental health and other conditions that may affect a person's behaviour. Several respondents raised the point that users of mental health and learning disability services may display challenging behaviour. They were concerned that this may lead to being removed and charged with a criminal offence rather than having their needs addressed. For example, the Alzheimer's Society were concerned that the new powers could be used to manage people with conditions such as dementia instead of putting in place care that will alleviate behavioural symptoms.

10.4 Respondents were concerned that judgements may be made about individuals at a time when clinicians are not in full possession of all the necessary information about a patient's condition. One respondent also pointed out that criminal charges or fines are likely to be of limited deterrent effect for people with limited mental capacity.

10.5 The Mental Health Foundation had further concerns about the powers affecting other groups of society. These included people with physical health issues that may be placed at risk from the physical process of removal, people with cultural or language requirements or difficulties where removal will be an easy option, those from black and minority ethnic communities (in particular young black men) who are often perceived to be more threatening than other groups in society and other vulnerable groups such as those who are homeless or those with drug and alcohol problems.

10.6 The Department understands and recognises the concerns raised and is keen that the potential for any adverse impact is minimised. Discussions are underway with relevant parties to explore this issue further and address these concerns through the development of a training programme and strict guidance.

Question 11: What safeguards do you think will need to be in place to prevent this from happening?

11.1 Responses here largely reflected the responses to question 7. For example, respondents mentioned the importance of training, particularly diversity, cultural and mental health awareness training, guidance, monitoring arrangements and access to interpreting services.

11.2 In addition, specific safeguards to prevent the implementation adversely affecting particular sections of society included access to skilled community workers and liaison with patient and service user groups and community groups and their specialist workers. One respondent suggested that an identifying logo be designed, which health bodies could use to indicate that the policy is in operation to overcome any barriers to understanding.

11.3 As mentioned above, one respondent felt that no safeguards would be adequate to prevent adverse impact on particular groups. Again, further work is being undertaken.

Question 12: How should this be monitored?

12.1 The importance of monitoring arrangements was widely acknowledged. Several respondents thought that incidents should not only be monitored locally but also at a national level. It was felt that incident reports should be completed on an ongoing basis with periodic reviews, possibly with local monitoring through Trust safety committees or Board reporting.

12.2 Specific aspects mentioned included thorough documentation of every aspect of the procedure, including ethnic and disability monitoring of the individuals concerned, the strategies used to avoid using physical removal and any injuries caused to the person as a result of the removal. These suggestions will be considered.

ANNEX A

LIST OF ORGANISATIONS / INDIVIDUALS RESPONDING TO CONSULTATION

Organisations
5 Boroughs Partnership NHS Trust
Addenbrookes NHS Trust
Airedale NHS Trust
Airedale PCT
Alzheimer's Society
Ambulance Services Association
Amicus
Association of British Dispensing Opticians
Association of Optometrists
Basildon & Thurrock University Hospitals NHS Trust
Berkshire Shared Services
Board of Community Health Councils in Wales
Bolton, Salford and Trafford Mental Health NHS Trust
Bradford Teaching Hospitals Foundation Trust
Brighton & Sussex University Hospitals NHS Trust
Bristol South and West PCT
British Association for Emergency Medicine
British Dental Association
Bro Morgannwg NHS Trust
Browne Jacobson
Burton Hospitals NHS Trust
Camden PCT
Cheltenham & Tewkesbury PCT
Cheshire and Wirral Partnership NHS Trust
College of Optometrists
Cornwall and the Isles of Scilly Primary Care Trusts
Cotswold & Vale PCT
County Durham & Darlington Acute Hospitals
Derbyshire Mental Health Services NHS Trust
East and North Hertfordshire NHS Trust, Paediatric ward
East Surrey PCT
East Sussex Hospitals NHS Trust
Epsom & St Helier University Hospitals NHS Trust
Federation of Ophthalmic and Dispensing Opticians (FODO)
George Eliot NHS Trust
GMB
Great Ormond Street Hospital for Children NHS Trust
Greater Peterborough Primary Care Partnership
Harrogate and District NHS Foundation Trust
Havering PCT
Health and Safety Executive

Home Office
Hull Adult Mental Health Service
Humber Mental Health Teaching NHS Trust
Institute of Occupational Safety and Health
Kettering General Hospitals NHS Trust
Lewisham Hospitals NHS Trust
London Ambulance Service NHS Trust
Maidstone and Tunbridge Wells NHS Trust
Mayday Healthcare NHS Trust
Mencap
Mental Health Foundation
Mid Sussex PCT
Mind
Moorfields Eye Hospital NHS Foundation Trust
North Bradford & Airedale PCT Consumer Council
North Bristol NHS Trust
North Cheshire Hospitals NHS Trust
North Derbyshire PCTs
North East Lincolnshire PCT
North Tees Teaching PCT
North West London Hospitals NHS Trust
Nottingham University Hospitals NHS Trust
Oxford City PCT
Parkhill Audit Agency
Pontypridd & Rhondda NHS Trust
Portsmouth City Teaching PCT
Portsmouth Hospitals NHS Trust
Preston PCT
Queen Elizabeth NHS Trust
Queen Victoria Hospital NHS Foundation Trust
Rethink
Rotherham PCT
Royal College of Nursing
Royal College of Physicians
Royal Pharmaceutical Society of Great Britain
Rushcliffe PCT
South Birmingham PCT
South Essex Partnership NHS Foundation Trust
South Huddersfield and Huddersfield Central Primary Care Trusts
South Tees Hospitals NHS Trust
South West London and St George's Mental Health Trust
South Western Ambulance Service NHS Trust
Southend Hospitals NHS Trust
Stockport NHS Foundation Trust
Suffolk Coastal PCT
Tees, Esk and Wear Valleys NHS Trust
The Blackburn with Darwen PCT,

The Cardiothoracic Centre NHS Trust
The College of Optometrists
The Hyndburn and Ribble Valley PCT
The Mid Yorkshire Hospitals NHS Trust
The National Autistic Society
The Newcastle upon Tyne Hospitals NHS Trust
The Pennine Acute Hospitals NHS Trust
The Royal Marsden
The Society of Radiographers
The Walton Centre for Neurology and Neurosurgery NHS Trust
Wandsworth Teaching PCT
West Dorset General Hospitals NHS Trust
West Gloucestershire PCT
Winchester and Eastleigh Healthcare NHS Trust
Worcestershire Primary Care and Mental Health Shared Services
Wrightington, Wigan and Leigh NHS Trust
Individuals
Anonymous Response # 1
Anonymous Response # 2
Anonymous Response # 3
Anonymous Response # 4
Anonymous Response # 5
Anonymous Response # 6
Anonymous Response # 7
Graham Archard, Royal College of General Practitioners
Elissa Avery, East Sussex Hospitals NHS Trust
Howard Beswick, South Central SHA
Danny Boardman, Sheffield Children's NHS Foundation Trust
Rohan Borschmann, South West London and St George's Mental Health Trust
Maureen Brown, Institute of Occupational Safety and Health
Merissa Burdall, East Hampshire PCT
Tracy Burrows, South West London and St George's Mental Health Trust
Drusilla Cherry, South West London and St George's Mental Health Trust
Steve Clarke, Trent Strategic Health Authority
Jean Clowes, North Middlesex University Hospital
Peter Cooney, London Ambulance Service NHS Trust
Sharon Dennis, Royal College of Nursing
Dave Doe, East Sussex Hospitals NHS Trust
Paul Ekwurke, South West London and St George's Mental Health Trust
Barrie Fairbairn
Clare Farr
Angela Gill, Whinfield Surgery, Darlington PCT
Meg Goodrick, Welwyn Hatfield PCT
Chris Hall, South West London and St George's Mental Health Trust
Julie Harrison, Welwyn Hatfield PCT

Martin Harrop, CW Audit Services
Dr Ian Harvey, South West London and St George's Mental Health Trust
Susan Harvey
Eillean Hawkins, Portsmouth Hospitals NHS Trust
David Henstock, Sherwood Forest Hospitals NHS Trust
Regine Hill, East Sussex Hospitals NHS Trust
Catherine Hinton, Causeway Health and Social Services Trust
George Hoggarth, University of Salford
Barry Jackson, North East Lincolnshire PCT
Chris Kinsler, East Lancashire Hospitals NHS Trust
Peter Lester, Addenbrookes NHS Trust
Andy Lloyd, Royal Brompton & Harefield NHS Trust
Fiona Lock, East Sussex Hospitals NHS Trust
Christine Lomas, Central Manchester and Manchester Children's University Hospitals NHS Trust
Stuart M
David McGrath, Gloucestershire Partnership NHS Trust
Phillip McShane, Nuffield Department of Surgery
Danny Morgan, York Hospitals NHS Trust
John O'Callaghan-Williamson
Jim O'Dwyer
Prof Ian Robbins, South West London and St George's Mental Health Trust
Stewart Russell, Barts and the London NHS Trust
Bryn Shaw, barnet, Enfield & Haringey Mental Health NHS Trust
Phil Smith, Boughton Health Centre, Cheshire West PCT
Peter Symkiss, Essex Rivers Healthcare NHS Trust
Arthur Tomkins, York Hospitals NHS Trust
Ged Towey, Salford City Council
Enid Waller, South West London and St George's Mental Health Trust
Val Watson, Gloucestershire Hospitals NHS Trust
Donna White, East and North Hertfordshire NHS Trust