

Health Service Circular



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Tackling violence towards GPs and their staff

The NHS (Choice of Medical Practitioner) Amendment Regulations 1999

For action by: Health Authorities (England) - Chief Executive
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For information to:

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It is also available on the Department of Health web site at
<http://www.doh.gov.uk/coinh.htm>

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Tackling violence towards GPs and their staff

The NHS (Choice of Medical Practitioner) Amendment Regulations 1999

Summary

This circular is intended to help HAs/PCTs/PCGs/practices and GPs implement proposals to address the problems of violent behaviour in General Practice, building on the measures which were introduced in 1994 [FHSL (94)24]. The guidance describes the amendment to the National Health Service (Choice of Medical Practitioner) Regulations 1998 and its effect, provides practical advice on the routes open to GPs and their staff to use the Criminal Justice System and also presents a model Local Development Scheme to provide GMS to violent patients.

Action

Health Authority Chairmen and Chief Executives as well as all GPs, PCT and PCG Chairs should bring this circular to the attention of their staff.

Introduction

1. i The Department of Health launched the NHS zero tolerance zone campaign in October 1999 to send out the message to the public that aggression, violence and threatening behaviour will no longer be tolerated by professionals and staff working in the health service. The definition of work related violence is not subjective. 'Violence' means:

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.

The Department of Health recognises that violent behaviour against GPs and their staff is a continuing concern to the profession and that action needs to be taken to make general practice a safer environment;

- ii. the statutory right of an individual to receive general medical services is a fundamental bedrock of the NHS and will remain. Any arrangements to reduce the risks of violence in general practice must recognise and build on this basic principle;
- iii. any initiative to make general practice safer must allow scope for local flexibility and must recognise the scale of the problem. Every violent incident against a GP or his or her staff is one too many. The number of recorded incidents of violence which have resulted in a GP seeking to have patients removed from their lists was 1,081 in England for the year 1996/97 is an underestimate of the true scale of the problem. This needs to be borne in mind when considering possible service options to reduce the risks of violence. While relatively few cases may arise in some areas, other areas could experience a correspondingly greater number. For this reason, a single national solution is unlikely to be workable; but local efforts to tackle the problem can be supported nationally.

- iv. HAs are expected to make resources available which will encourage GPs to participate in local initiatives to tackle violence. GP participation in local initiatives should be at all times voluntary. HAs should develop these initiatives in close consultation with LMCs.
2. The Department's proposals for action involve:-
 - cross-Government work, including promoting greater understanding of the criminal justice system;
 - a requirement for local action supported by service flexibilities;
 - changes to regulations.
 - using powers under section 1 of the Crime and Disorder Act to obtain anti-social behaviour orders or resorting to the Protection from Harassment Act 1997.

Making better use of the Criminal Justice System

3. As part of the cross-Government drive against violence to staff in the NHS, ***the NHS Zero Tolerance Zone***, national guidelines have been issued to explain what happens after a case is reported. Details on what happens after a case is reported to the police are reproduced at Annex 2.
4. Health authorities should ensure that appropriate and effective support is offered to GPs or their staff who have been the victims of violence. Health Authorities should have plans on how to achieve this, which will include advice on the reporting of incidents to the police and the prosecution process i.e a realistic evaluation of the evidence. This might also, in appropriate circumstances, extend to advice on the issue of injunctions to enable GPs to protect themselves, their staff and premises. Liaison should be made with the LMC which may have established local support and counselling services for GPs.
5. It is not generally possible for health authorities to apply for injunctions where violent patients have been removed from their GP's list under Regulation 9A. Injunctions are discretionary remedies only available to the victim. The application must be made by the person who was the subject of the violent incident, or threatened violence.
6. The Crime and Disorder Act 1998 outlines the concept of Crime and Disorder Audits. There is a responsibility on the police to consult with HAs under section 5 of the Act. HAs should include the views of general practitioners and LMCs in their contribution to these audits.

Local Action

7. When considering new mechanisms for countering violence it is helpful to know the extent of the problem. The recent document "The New NHS: Working Together" recognises the need to have systems in place to record and monitor violence against staff. This principle needs to include general practice. At present the numbers of patients immediately removed because of violence is counted but this might not be representative of all such incidents. A more comprehensive recording of the number and nature of incidents of violent or threatening behaviour in general practice should be introduced at health authority level and would involve the voluntary reporting by GPs of violent incidents, including incidents which contain an element of threatening behaviour rather than explicit violence, where removal of the patient was not being sought.

8. The issue of violent behaviour varies from health authority to health authority and the circumstances leading to this type of behaviour are also different from area to area. The emphasis therefore needs to be on local solutions developed as part of the national initiative to reduce violence.
9. Health authorities should develop a local action plan for combating violence in discussion with interested local groups. As a minimum these would include LMCs, PCGs, the police, local trusts and the local CHC. Features of a local action plan would be incorporated into the crime and disorder audit and would include:
 - better recording mechanisms which allow GPs to report incidents even if they are not seeking an immediate removal;
 - support and advice services for the victims of violence;
 - mechanisms for providing GMS to violent patients in a limited number of locations. If this is what local GPs feel is necessary, these could be within GP practices, in hospitals, at police stations etc or in a combination of different types of location;
 - arrangements for police/security support for GPs undertaking home visits and surgery consultations where the GP has reason to believe there is a risk of violence;
 - support for any security investment needed to deliver the action plan;
 - written co-operation arrangements between the HA and the local police, and if necessary other organisations;
 - use of Local Development Schemes and PMS pilots as a means of organising the provision of GMS to violent patients and funding any incentivised support needed to encourage practices to treat and retain violent patients;
 - arrangements to protect the interests of the families of violent patients; and
 - arrangements for the protection of mentally ill patients.
10. Health authorities will be expected to prepare their action plan during 1999/2000 and to have these in place by April 2000. These action plans will be complemented by central Departmental action to:-
 - work with the Home Office to find ways to engage Chief Constables on the importance of local collaboration with health authorities to tackle the risks faced by GPs and their staff; and
 - encourage health authorities to make use of existing flexibilities provided by Local Development Schemes and PMS Pilots. Attached as an Annex is an outline of how a Local Development Scheme for these patients might be designed. We also propose to include a reference to violence in the PMS guidance to support the use of pilots to address the issue of violence. The role of PMS pilots in offering services to violent patients should not be overlooked and their location in Trust premises may be beneficial in terms of overall security.
11. The use of flexibilities based on PMS pilots and Local Development Schemes to tackle violence should involve volunteers. The HA may encourage GPs to participate in a Local Development Scheme but if GPs are not prepared to volunteer to join a scheme they cannot be obliged to take this on.

Regulations

12. Violent patients will not be excluded from receiving general medical services but their behaviour compromises their right to access general medical services in normal locations. Regulations have been amended to support the type of local solutions that are envisaged, in particular the delivery of GMS by a GP only in specified premises.

13. To facilitate this an amendment to regulations 4 & 5 of the Choice of Medical Practitioner Regulations came into force on 20 December 1999. The effect of this provides that where the patient seeking assignment had been removed from a doctors list under the provisions of regulation 9A of the GMS Regulations, the health authority shall have regard to the availability of appropriate security facilities at the practice that they assign the patient to. The intention of the new regulation is to allow health authorities to override considerations about the distance between the person's residence and the practice premises in respect of these patients. This means that a health authority should make arrangements to ensure that a patient who has been removed from a GP's list because of violent or threatening behaviour attends suitable premises for the purpose of receiving medical attention regardless of where these premises are. These are of course measures which would not be taken lightly but it is important to understand the effect of the amendment to the Regulation.
 14. The existing regulations concerning Local Development Schemes and PMS Pilots are already suitable for the purposes of this circular.
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This circular has been issued by:

Dr Sheila Adam
Health Services Director

ANNEX 1

MODEL LOCAL DEVELOPMENT SCHEME FOR PATIENTS WHO HAVE BEEN SUBJECT TO IMMEDIATE REMOVAL FROM A GP'S PATIENT LIST

Introduction

1. HAs are expected to have access to a Local Development Scheme which may, if necessary, be in another local HA area. This paper sets out a possible model of a Local Development Scheme (LDS) for the provision of general medical services for those patients who have been subject to immediate removal from a GP's patient list.

The scope of Local Development Scheme

2. Local Development Schemes are for the provision of general medical services. They allow for the enhancement of fees to individual GPs or to GP practices, where provision of services to a specified standard or in a certain way can be demonstrated. In the context of those patients who have been subject to immediate removal from a GP's patient list, practices are presented with the additional difficulty of treating the patient in a way which minimises the risk of violence or disruption to the GP, practice staff and other patients. Handling these problems can make the delivery of GMS difficult and can restrict the patient's access to wider facilities. These patients may also experience difficulties in securing registration with a GP without the help of the health authority. Placing them on a rota of short term assignments whilst spreading the workload does little to address the health and social care needs of the patients, which may be complex and wide ranging.

Aims

3. The purpose of an LDS for patients who have been subject to immediate removal from a GP's patient list would be to provide a stable environment for the patient to receive continuing healthcare, addressing any underlying causes of aggressive behaviour and providing a safe environment for the individuals involved in delivering that treatment. The model does this by:
 - i. incentivising GPs to retain, on a longer term basis, those patients that are potentially aggressive (i:e those who are compulsorily allocated following their removal by another practice because of violent behaviour). This could be by an annual payment, additional capitation for the potentially aggressive patient, by specific security investments in the practice or by a combination of these. This will provide a stable environment in which the health needs of the patient can be addressed in a proper and continuing manner;
 - ii. encouraging GPs to work with other primary care practitioners, social services and other Agencies to try and identify and treat any clinical, and underlying, causes of disruptive behaviour so as to prevent further deterioration;
 - iii. promoting a continuing understanding of the NHS health and social care system so as to encourage the patient to use the services in a responsible and safe way in the future; and
 - iv. safeguarding the families of patients who have been subject to immediate removal from a GP's patient list who are, on occasions, themselves subject to removal. Providing a stable environment for treating the patient will, just as importantly, have the effect of providing similar stability for any family members.

The medical care needs of the families of patients who have been subject to immediate removal will need to be considered on a case by case basis. Often it will be appropriate for them to remain registered with the original doctor, who should be protected by an injunction from approaches by the removed person on behalf of family members.

Policy Considerations

4. Health authorities could enter into Local Development Schemes with a small number of practices, sufficient to give a reasonable geographical split, in their area. These arrangements would provide long term medical care for patients who have been subject to immediate removal from a GP's patient list. The aim should be to break the cycle of short-term assignments, for example by the GP undertaking to maintain the patient's registration for at least twelve months. Short term assignments do little to address the health and social needs of the patient or endear general practice to the patient. Neither do they afford protection to GPs and their staff.
5. The agreements should work within any local arrangements for dealing with violence that have been entered into by the health authority with LMCs, the police, other agencies or other parts of the NHS.
6. The incentivising of the schemes will depend on the nature of the local arrangements for handling patients who have been subject to immediate removal from a GP's patient list. For example, in addition to a possible enhanced capitation fee, where patients are seen at a secure facility that is away from the doctor's normal surgery premises the payment might recompense the GP for the additional difficulties/costs in seeing the patient. Where they are seen in the practice it might also fund security investments (staffing, including access to security guards, or premises improvements). Finance for specific staff training could also be beneficial so as to build up the confidence of all of those who come into contact with the patient.
7. Health authorities should be mindful of the need to protect patient confidentiality by avoiding, where practical, data flows, for payment or other purposes, which identify individuals. However, it is well recognised that there is considerable value in the sharing of relevant information between agencies so as to give prior warning of the possibility of violent behaviour. Doctors and providers should be encouraged to share information between health, social services, prison, police and other relevant sources to build up a picture of past behaviour so that risk can be assessed.

How would a local development scheme for the potentially aggressive work?

8. When a GP requests the immediate removal of a patient because of an act or threat of violence the health authority is notified. The health authority is then expected to assign the patient to a new GP as quickly as possible, at the same time notifying the new GP of the history of aggressive behaviour. Health authorities record these requests for removal and this forms the basis of an annual return to the NHS Executive. Health authorities are therefore in a position to identify those who have been violent in the past and produce planning projections of the number of requests they might receive in the future. As part of this process it is important that the health authority does everything possible to ensure that the new doctor receives the patient's medical record before they have to see the patient.
9. Health authorities should assign these potentially violent patients to a practice participating in the LDS.

Clinical role

10. The scheme should provide for a thorough assessment of the patient's clinical, psychological and social needs, especially those which may result in unrealistic expectations and which may have led to physical or verbally aggressive behaviour in the past.
11. The scheme should provide time to educate the patient and his/her family/carer on the best way to obtain good quality and continuing services from primary care in particular and the NHS in general. Health authority input into this should be considered to demonstrate to the patient that it is the health authority, with the input of the GP, who has decided to include the patient into this particular pattern of care.
12. The patient would need to be clearly informed that they were being assigned to the LDS practice specifically because of their previous violent behaviour. It should be made clear to the patient that they are not being excluded from receiving general medical services but that their behaviour compromises their access to normal arrangements and locations for receiving it. However, this should be a private matter and every effort should be made to avoid a practice becoming labelled as a "violent patient unit" as this might stigmatise the service or discourage the wider population from using the practice.

Review

13. The scheme should be time limited. It would not be appropriate for a patient to be treated under the LDS without time limit. Controls will be for local discussion but could, for example, consist of a twelve-month review. This would be initiated by the GP and would give an opportunity to consider whether or not the patient should continue under the LDS, and would be supplemented by a more wide ranging three yearly review where the health authority might seek more substantive justification for a continuance (eg that the patient could not learn new behaviour because of an underlying personality disorder).

Security

14. In upgrading security within practices the aim should not be to adversely affect the outward appearance of the practice in a way which might make existing patients uneasy about the security environment. Security should wherever possible be discreet, but effective, rather than overt.

Numbers of patients

15. An LDS for patients who have been subject to immediate removal from a GP's patient list should be responsive to local conditions, such as the numbers of potential patients. A rigid maximum and minimum number is unlikely to be helpful. The aim should be to encourage practitioners to build up a special interest and commitment to such patients while not placing too many violent patients into one practice as this could detract from the services available to existing patients. Health authorities are not constrained by patient choice in assigning these patients.

Benefits

16. GPs and their staff will be more expert and confident in handling patients who have been subject to immediate removal from a GP's patient list. This outward confidence will also reduce the potential for conflict and hence reduce the risk of a violent or threatening response.

17. The patient will become better educated as to the impact of any anti social behaviour on the caring professions and will learn to get the best from the NHS.
18. The patient, and where necessary their family, will get continuity of care through one practice. This is especially important to counter impressions of abandonment by the NHS which may have been a cause of previous violent behaviour.
19. The patient will become aware that their only source of primary care is through the one practice and being disruptive will not get them a new doctor or make them the centre of attention. (The patient retains their right to approach any GP and seek registration but given the likely natural reluctance to take on a patient who has been subject to immediate removal from a GP's patient list these individuals have to rely heavily on assignment for a doctor.) The HA should notify the new GP that the patient has been removed under paragraph 9a. HAs are expected to work towards these arrangements and make GPs aware that an LDS is in place.
20. The stability offered will lead to an improved doctor/patient relationship in which both the patient and the doctor can work constructively together to provide a wide range of health and social services.
21. The practice will be recompensed for the additional effort/risk associated with providing medical care for potentially violent individuals.

ANNEX 2

What happens after a case is reported to the police?

The police are responsible for investigating crimes, and will charge offenders when there is sufficient evidence to do so.

Alternatively, the police may decide to issue a warning, or to formally caution an individual. A caution is sometimes given by the police where an offence has been committed but they decide not to take the person to court because that person has admitted the offence and agreed to be cautioned. Whether a caution is an appropriate response will depend upon the seriousness of the offence and agreed to be cautioned. Whether a caution is an appropriate response will depend upon the seriousness of the offence and will involve consideration of such factors as the offender's previous record and his/her attitude to the offence.

A police caution is not an easy option when dealing with an offender but is a serious form of disposal and will affect how that person is dealt with in future. Records of all cautions for reportable offences are entered on to the Phoenix database of the Police National Computer. Should the person re-offend, the fact that he or she has a previous caution will be a factor in the police decision whether or not to prosecute. In addition, a previous caution may be cited in court and could, therefore, increase any sentence received for the new offence.

If the police decide to charge someone, the case is passed to the Crown Prosecution Service [CPS]. The CPS is a national service which prosecutes criminal cases in England and Wales referred to them by the police. CPS lawyers are governed by the Code for Crown Prosecutors. All cases have to be reviewed to make sure that they pass the two tests set out in the Code. The first test is the evidential test – there has to be sufficient evidence for there to be a realistic prospect of a conviction. Criminal cases have to be proved beyond reasonable doubt, so there must be clear and reliable evidence that the offence was committed. In assault cases it is necessary to prove that the offender either meant to harm someone, or knew that his/her behaviour created a risk of harming someone, but still carried on.

It is only if the papers pass the evidential test that the second test is applied. This is the public interest test. The Code says "although there may be public interest factors against prosecution in a particular case, often the prosecution should go ahead". The Code sets out public interest factors in favour of prosecution. It states that " a prosecution is likely to be needed if..... the offence was committed against a person serving the public (for example, a police or prison officer or a nurse)".

Assaults against staff working in the NHS are therefore regarded as serious matters, worthy of prosecution.

Where are the cases heard?

All criminal cases begin with a hearing in a magistrates' court. Assaults are dealt with both in the magistrates' court and the Crown Court. Some assault charges can only be dealt with in the magistrates' court where the maximum penalty is six months imprisonment. The advantages of hearings in the magistrates' court are that they can be dealt with more quickly, the courthouse is likely to be more local to witnesses, and hearings are more informal, so it is easier to be at ease when giving evidence.

Most serious charges of assault are dealt with in the Crown Court, where there are greater powers of punishment. Some cases can be heard either in the Crown Court or the magistrates' court. The alleged offender has a choice as to where the case is heard but the magistrates have to be satisfied that their powers of punishment are sufficient before they agree to hear the case.

To help magistrates decide whether to hear a case, guidelines have been issued by the Lord Chief Justice – the National Mode of Trial Guidelines 1995. These set out factors that make a case more serious. In cases of violence, one of these factors is “serious violence...caused to those whose work has to be done in contact with the public or who are likely to face violence in the course of their work”.

What happens if I am required to give evidence as a witness?

The police will tell you if you need to appear in court as a witness. All agencies within the criminal justice system work together to provide a co-ordinated service to witnesses, implementing national standards of witness care. Giving evidence in court can be stressful but the people involved - the police, the CPS and court staff - will give you as much information as possible about what is likely to happen. All Crown Courts and many magistrates' courts have Witness Service Schemes run by Victim Support and local magistrates' courts charters set standards of service to witnesses. The CPS has made a public declaration of its principles in the CPS Statement of Purpose and Values: “We will show sensitivity and understanding to victims and witnesses”.

Information about standards of victim/witness care can be found in the following publications:

- *Statement on the treatment of victims and witnesses by the CPS* – explains CPS policies about victims and witnesses and how commitments are put into practice;
- Home Office leaflet “*Witness in Court*” – tells witnesses what to expect when asked to go to a magistrates' court or the Crown Court to give evidence.
- Home Office publication “*The Victim's Charter*” – a statement of service standards for victims of crime.
- Court Service publication “*Court Charter*” – sets out important standards which can be expected in the Crown Court.
- Each Magistrates' Courts' Committee publishes their own charter, available from local magistrates' courts.

Sentencing

You may attend the sentencing hearing if you wish, even if you were not present at earlier hearings as a witness. The CPS will keep you informed about the progress of a case and tell you when your attacker is to be sentenced. An unexpected guilty plea at an earlier hearing could however result in sentence being given immediately. The sentence is a matter for the court alone; magistrates and judges are independent from any individual or organisation.

In sentencing the judge or magistrates take into account all the circumstances in which the offence occurred and those of the offender:

- The circumstances of the offence will be known to the court if your attacker has pleaded not guilty and a trial has taken place. If they have pleaded guilty the prosecutor will set out the facts of the case.
- The circumstances of the offender will be available to the court from:
 - the defendant's legal representative when presenting mitigation to the court;
 - the defendants themselves if not legally represented;

the probation service, medical or psychiatric reports ordered by the courts.

- The sentencing guidelines, issued by the Magistrates Association to its members, make it clear that an assault is made more serious if the victim is a person who is assaulted while serving the public.
- The Lord Chancellor, who is also President of the Magistrates Association, has said that it is entirely legitimate for magistrates to respond decisively to a particular form of criminal behaviour, such as assaults on NHS staff, and to impose a sentence which has a deterrent component.
- Magistrate's courts can impose up to six months imprisonment for common assault or assault occasioning actual bodily harm. If appropriate magistrates' courts can commit to the Crown Court which can pass a stiffer sentence. The Crown Court can impose substantial periods of imprisonment and, in cases involving the very worst type of attacks, a sentence of life imprisonment may be imposed.

Compensation

Magistrates can award compensation for personal injury, loss or damage up to a total of £5,000 for each offence. You can expect the court to consider the possibility of compensation whether or not you make a claim, but if there is any information you wish the court to consider in this respect, you should pass this to the Crown Prosecution Service. If no compensation is given you can expect the magistrates to give their reasons for not making an award. Compensation may only be awarded if the offender has means.

Whether or not a criminal court awards you compensation you may pursue a separate claim in the civil courts either privately or with the assistance of your union/professional association or NHS employer.

Another way of seeking compensation is through the Criminal Injuries Compensation Scheme. If you have been injured because of a crime of violence you can apply for compensation under the scheme. It doesn't matter whether the offender has been caught or not. Copies of the information pack with an application form can be obtained from the Police, Victim Support, Citizens Advice Bureau or direct from the Criminal Injuries Compensation Authority, Tay House, 300 Bath St, Glasgow, G2 4JR. Tel 0141 331 2726

Further reading

NHS Executive publications:

Copies of the following publications can be obtained by ringing the NHS Responseline – Tel: 0541-555455.

“Working Together: Securing a quality workforce for the NHS” (1998).

“Staff Health, Safety and Welfare” (1998).

“Effective management of security in A&E” (1997).

“Safer Working in the Community” (1998) published jointly with the Royal College of Nursing. Copies are also available from RCN Direct (Re-order No. 000 920).

Other publications:

Copies of the following publications can be obtained by contacting the relevant organisation direct (contact details are given at the end of this Resource Sheet).

“Guidance on Statutory Crime and Disorder Partnerships: Crime and Disorder Act 1998” (1998) available from the Crime Reduction Unit in the Home Office.

“Witness in Court” – available from the Home Office

“The Victim’s Charter” – available from the Home Office

“Victims of Crime” – available from local police or the Home Office

“Victims of Crime of Violence” – available from the Criminal Injuries Compensation Authority

“Violence” – available from both local offices or the national office of Victim Support

“The Crown Prosecution Service” – available from the Crown Prosecution Office (CPS)

“Code for Crown Prosecutors” – available from the Crown Prosecution Office (CPS)

“Statement on the treatment of victims and witnesses” – available from the Crown Prosecution Service (CPS)

“Courts Charters” – available from the Court Service

Magistrates’ Courts Charters – available from local magistrates’ courts

“Going to Court” – available from both local and national office of Victim Support

“Working for Victims of crime” – available from both local and national office of Victim Support

“Review on Violence to NHS staff Working in the Community” available from Violence Research Group, University of Nottingham

“Dealing with violence against Nursing Staff” available from RCN Direct.

“Violent Times” available from the TUC Health and Safety Unit.

“Violence and Aggression to staff in the health services” available from HSE Books.

“Preventing Violence to Staff” available from HSE Books.

“Everyone’s guide to Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995” available from HSE Books.

“Violence at Work, A guide to risk prevention for UNISON branches, stewards and safety representatives” (1999) available from UNISON.

“Management of Imminent Violence” (1998) available from the Royal College of Psychiatrists.

“Personal Safety at Work: Guidance for all Employees” available from the Suzy Lamplugh Trust.

“Combating violence in general practice: Guidance for GPs” available from the British Medical Association.

“Risk Assessment at Work: Practical Examples in the NHS” available from Health Education Authority

Useful Contacts for further information

NHS Executive HQ

Quarry House
Quarry Hill
Leeds LS2 7UE.

Enquiries Tel: 0113 2545000

Publications Tel: 0541 555455 (NHS Responseline)

Home Office

50 Queen Anne's Gate
London SW1H 9AT.

Enquiries Tel: 0171 273 4000

Publications Tel: 0171 2732066

Crown Prosecution Service Headquarters

50 Ludgate Hill
London EC4M 7EX.

Enquiries Tel: 0171 3348505

Publications Tel: 0171 2738078

Health and Safety Executive

Rose Court
Magdalen House
2 Southwark Bridge Road
London
SE1 9HS

HSE InfoLine Tel: 0541 545500

or write to HSE Information Centre Boar Lane
Sheffield S3 7HQ.

HSE Books

PO Box 1999
Suffolk CO10 6FS.

Tel: 01787 881165

Criminal Injuries Compensation Authority

Tay House
300 Bath Street
Glasgow
G2 4JR

Tel: 0141 331 2726

Victim Support

National Office
Cranmer House
39 Brixton Road
London SW9 6DZ

Tel: 0171 7359166

(The Victim Support Scheme is a national charity providing help and information through a network of local schemes. They can be contacted on the above number. Alternatively check your local phonebook or with the local police for the number of your local scheme)

Court Service Headquarters

Southside, 105 Victoria Street,
London SW1E 6QT.

Customer Service Unit Tel: 0171 210 2266
e-mail: cust.ser.cs@gtnet.gov.uk

The Suzy Lamplugh Trust

Trust Office

14 East Sheen Avenue
London SW14 8AS

Tel: 0181 392 1839

Training Office
PO Box 17818
London SW14 8WW

Tel: 0181 8760305

Citizens' Advice Bureau

(check in local phonebook)

Royal College of Nursing (RCN)

20 Cavendish Square
London W1M 0AB

Tel: 0171 4093333

RCN Work Injured Nurses Group (WING) Tel: 0181 681 4030

RCN Nurseline Tel: 0181 681 4030

RCN Counselling Service Tel: 0345 697 064

RCN Direct Tel: 0345 726 100 (a 24-hour telephone service offering information and advice for RCN members).

UNISON

1 Mabledon Place
London WC1H 9AJ.

Tel: 0171 3882366

British Medical Association (BMA)

BMA House
Tavistock Square
London WC1H 9JP.

Tel: 0171 3874499

BMA Counselling Service (a service for members and their families)

Tel: 0645 200169

TUC (Trade Union Congress)

Health and Safety Unit

Congress House
Gt. Russell Street
London WC1B 3LS.

Tel: 0171 6364030

Violence Research Group

School of Psychology
University of Nottingham
Nottingham NG7 2RD.

Tel: 0115 9515151 ext 18261

Health Education Authority (HEA)

Trevelyan House
30 Great Peter Street
London SW1P 2HW.

Tel: 0171 4131873

Useful Websites

Department of Health - www.doh.gov.uk

Home Office - www.homeoffice.gov.uk

Criminal Justice System - www.criminal-justice-system.gov.uk

Crown Prosecution Service – www.cps.gov.uk

Court Service – www.courtservice.gov.uk

The Suzy Lamplugh Trust - www.suzylamplugh.org

Action

This Circular has been issued by:

Dr Sheila Adam
Health Services Director