NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Violence and aggression

Output: Prioritised quality improvement areas for development.

Date of Quality Standards Advisory Committee meeting: 16 November 2016

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1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for violence and aggression. It provides the committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the committee in considering potential statements and measures.

1.2 Development source

The key development source referenced in this briefing paper is:

Violence and aggression: short-term management in mental health, health and community settings. NICE guideline 10 (2015).

2 Overview

2.1 Focus of quality standard

This quality standard will cover short-term management of violent and aggressive behaviour in adults, children and young people with a mental health problem. It covers mental health, health and community settings, including care delivered in people's homes. It will not address violence and aggression among people with primary diagnosis of learning disability as this is covered by QS101 - Learning disabilities: challenging behaviour.

2.2 Definition

Violence and aggression refer to a range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is physically or verbally expressed, physical harm is sustained or the intention is clear.

2.3 Incidence and prevalence

Violence and aggression are relatively common and serious occurrences in health and social care settings. Between 2014 and 2015 there were 68,683 assaults reported against NHS staff in England[1]:

- 67% in mental health or learning disability settings
- 28% involving acute hospital staff
- 3% against ambulance staff
- 2% involving primary care staff.

Violence and aggression in mental health settings occur most frequently in inpatient psychiatric units and most acute hospital assaults take place in emergency departments.

2.4 Manifestation and management

The manifestation of violence and aggression depends on a combination of intrinsic factors, such as personality characteristics and intense mental distress, and extrinsic factors, such as the attitudes and behaviours of surrounding staff and service users, the physical setting and any restrictions that limit the service user's freedom. The impact of violence and aggression is significant and can affect the health and safety of the service user, other service users in the vicinity, carers and staff.

Management of violence and aggression varies across settings but there is a drive to reduce the use of restrictive interventions. Prevention and de-escalation are the preferred initial options. However, if these fail, restrictive intervention can include observation, seclusion, manual restraint, mechanical restraint and rapid tranquilisation.

2.5 National outcome frameworks

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 NHS outcomes framework 2016–17

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Improvement areas*** **Reducing premature mortality in people with mental illness** 1.5 i Excess under 75 mortality rate in adults with serious mental illness*

[1] NHS Protect (2015) Reported physical assaults on NHS staff figures 2014-15.

Domain	Overarching indicators and improvement areas
	*ii Excess under 75 mortality rate in adults with common mental illness** *iii Suicide and mortality from injury of undetermined intent among people with recent contact from NHS services***
2 Enhancing quality of life for people with long-term conditions	***Overarching indicator*** 2 Health-related quality of life for people with long-term conditions** ***Improvement areas*** **Enhancing quality of life for people with mental illness** 2.5 i Employment of people with mental illness** *ii Health-related quality of life for people with mental illness***
3 Helping people to recover from episodes of ill health or following injury	***Improvement areas*** **Improving outcomes from planned treatments** 3.1 Total health gain as assessed by patients for elective procedures *i Physical health-related procedures* *ii Psychological therapies* *iii Recovery in quality of life for patients with mental illness*
4 Ensuring that people have a positive experience of care	***Overarching indicators*** 4a Patient experience of primary care i GP services ii GP Out-of-hours services iii NHS dental services 4b Patient experience of hospital care 4c *Friends and family test* *4d Patient experience characterised as poor or worse* *I Primary care* *ii Hospital care* ***Improvement areas*** **Improving people's experience of outpatient care** 4.1 Patient experience of outpatient services **Improving hospitals' responsiveness to personal needs** 4.2 Responsiveness to inpatients' personal needs **Improving people's experience of accident and emergency services** 4.3 Patient experience of A&E services **Improving experience of healthcare for people with mental illness** *4.7 Patient experience of community mental health services* **Improving children and young people's experience of healthcare**

Domain	Overarching indicators and improvement areas
	4.8 Children and young people’s experience of inpatient services
5 Treating and caring for people in a safe environment and protecting them from avoidable harm	***Overarching indicators*** *5a Deaths attributable to problems in healthcare* *5b Severe harm attributable to problems in healthcare* ***Improvement areas*** **Improving the culture of safety reporting** 5.6 Patient safety incidents reported
Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

Table 2 Adult social care outcomes framework 2015–16

Domain	Overarching and outcome measures
1 Enhancing quality of life for people with care and support needs	***Overarching measure*** 1A Social care-related quality of life** ***Outcome measures*** **People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation** 1H Proportion of adults in contact with secondary mental health services living independently, with or without support*
3 Ensuring that people have a positive experience of care and support	***Overarching measure*** **People who use social care and their carers are satisfied with their experience of care and support services** 3A Overall satisfaction of people who use services with their care and support 3B Overall satisfaction of carers with social services *Placeholder 3E The effectiveness of integrated care* ***Outcome measures*** **Carers feel that they are respected as equal partners throughout the care process** 3C The proportion of carers who report that they have been included or consulted in discussions about the person they care for **People know what choices are available to them locally, what they are entitled to, and who to contact when they need help** 3D The proportion of people who use services and carers who find it easy to find information about support **People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual** This information can be taken from the Adult Social Care Survey and used for analysis at the local level.
4 Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm	***Overarching measure*** 4A The proportion of people who use services who feel safe** ***Outcome measures*** **Everyone enjoys physical safety and feels secure** **People are free from physical and emotional abuse, harassment, neglect and self-harm** **People are protected as far as possible from avoidable harm, disease and injuries** **People are supported to plan ahead and have the freedom to manage risks the way that they wish**

Domain	Overarching and outcome measures
	4B The proportion of people who use services who say that those services have made them feel safe and secure *Placeholder 4C Proportion of completed safeguarding referrals where people report they feel safe*

Alignment with NHS Outcomes Framework and/or Public Health Outcomes Framework

* Indicator is shared

** Indicator is complementary

Indicators in italics in development

Table 3 Public health outcomes framework for England, 2016–2019

Domain	Objectives and indicators
1 Improving the wider determinants of health	***Objective*** Improvements against wider factors which affect health and wellbeing and health inequalities ***Indicators*** 1.06 Adults with a learning disability/in contact with secondary mental health services who live in stable and appropriate accommodation** 1.07 Proportion of people in prison aged 18 or over who have a mental illness 1.08 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services*, ** 1.11 Domestic abuse 1.12 Violent crime (including sexual violence) 1.13 Levels of offending and re-offending 1.16 Utilisation of outdoor space for exercise/health reasons 1.18 Social isolation
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities ***Indicators*** 4.09 Excess under 75 mortality rate in adults with serious mental illness* 4.10 Suicide rate** 4.11 Emergency readmissions within 30 days of discharge from hospital*
Alignment with Adult Social Care Outcomes Framework and/or NHS Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

3 Summary of suggestions

3.1 Responses

In total 15 stakeholders responded to the 2-week engagement exercise 22/09/2016 – 6/10/2016. Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. NHS Improvement's patient safety division submitted comments and referenced a full patient safety report. The responses have been merged and summarised in table 4 for further consideration by the Committee:

Table 4 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Anticipating violence and aggression • Risk assessments • Care planning	SCM, SBP, NHSP, RCN, NCD
De-escalation	MIND, SCM, NHSP, NCD
Prevention interventions • Medication • Psychological support	SCM
Using restrictive interventions • Physical health and monitoring of vital signs • Post incident debrief and formal review	NHSP, MIND, NCD, RCN, SCM, NHSI
Working with the police	HC, SCM, NHSP
Additional areas	RCGP, SCM, RCN, NCD, NHSP
HC, Hampshire Constabulary MIND NCD, National clinical director for mental health NHSI, NHS Improvement	NHSP, NHS Protect RCN, Royal College of Nursing SBP, Surrey and Borders Partnership NHS Foundation Trust SCM, Specialist Committee Member

Full details of all the suggestions provided are given in appendix 2 for information.

3.2 Identification of current practice evidence

Bibliographic databases were searched to identify examples of current practice in UK health and social care settings; 1548 papers were identified for violence and aggression. In addition, 30 papers were suggested by stakeholders at topic engagement and 5 papers internally at project scoping.

Of these papers, 4 have been included in this report and are included in the current practice sections where relevant. Appendix 1 outlines the search process.

4 Suggested improvement areas

4.1 Anticipating violence and aggression

4.1.1 Summary of suggestions

Risk assessments

Stakeholders highlighted the importance of using structured risk assessments to predict escalation of behaviour to violence and aggression. In particular the environment of the ward or setting was highlighted as of particular importance.

Care planning

Stakeholders suggested that patients who are likely to present with violence and aggression or patients who have presented with violence and aggression should have a care plan which includes triggers and management strategies.

4.1.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are also presented in full underneath the table to help inform the committee's discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Risk assessment	NICE NG10 Recommendation 1.2.10
Care planning	NICE NG10 Recommendation 1.3.16

Risk assessment

NICE NG10 Recommendation 1.2.10

Carry out the risk assessment with the service user and, if they agree, their carer. If this finds that the service user could become violent or aggressive, set out approaches that address:

- service user-related domains in the framework (see recommendation 1.2.7)
- contexts in which violence and aggression tend to occur
- usual manifestations and factors likely to be associated with the development of violence and aggression

- primary prevention strategies that focus on improving quality of life and meeting the service user's needs
- symptoms or feelings that may lead to violence and aggression, such as anxiety, agitation, disappointment, jealousy and anger, and secondary prevention strategies
- focusing on these symptoms or feelings
- de-escalation techniques that have worked effectively in the past
- restrictive interventions that have worked effectively in the past, when they are most likely to be necessary and how potential harm or discomfort can be minimised.

Care planning

NICE NG10 Recommendation 1.3.16

Encourage service users to recognise their own triggers and early warning signs of violence and aggression and other vulnerabilities, and to discuss and negotiate their wishes should they become agitated. Include this information in care plans and advance statements and give a copy to the service user.

4.1.3 Current UK practice

No data on current practice was found related to risk assessment and care planning. This area is based on stakeholder's knowledge and experience.

4.1.4 Resource impact assessment

No resource impact was anticipated from recommendations in this area of NG10. This is because it is considered that where clinical practice changes, as a result of the guidance, there will not be a significant change to resource impact.

De-escalation

4.2.1 Summary of suggestions

De-escalation

Stakeholders highlighted that de-escalation techniques help prevent violence and aggression and can result in fewer restrictive interventions. Relationships with staff and staff attitude were highlighted as core components.

4.2.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are also presented in full underneath the table to help inform the committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
De-escalation	NICE NG10 Recommendations 1.3.18, 1.3.19 and 1.3.20

NICE NG10 Recommendation 1.3.18

If a service user becomes agitated or angry, 1 staff member should take the primary role in communicating with them. That staff member should assess the situation for safety, seek clarification with the service user and negotiate to resolve the situation in a non-confrontational manner.

NICE NG10 Recommendation 1.3.19

Use emotional regulation and self-management techniques to control verbal and non-verbal expressions of anxiety or frustration (for example, body posture and eye contact) when carrying out de-escalation.

NICE NG10 Recommendation 1.3.20

Use a designated area or room to reduce emotional arousal or agitation and support the service user to become calm. In services where seclusion is practised, do not routinely use the seclusion room for this purpose because the service user may perceive this as threatening.

4.2.3 Current UK practice

No data on current practice was found related to use of de-escalation techniques. This area is based on stakeholder's knowledge and experience.

4.2.4 Resource impact assessment

No resource impact was anticipated from recommendations in this area of NG10. This is because it is considered that where clinical practice changes, as a result of the guidance, there will not be a significant change to resource impact.

4.3 Prevention interventions

4.3.1 Summary of suggestions

Medication

Stakeholders suggested that there is over reliance on medication to prevent violence and aggression.

Psychological support

Stakeholders suggest that psychological support can lead to reduction in violence and aggression.

4.3.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are also presented in full underneath the table to help inform the committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Medication	NICE NG10 Recommendations 1.3.10 and 1.3.11
Psychological support	NICE NG10 Recommendations 1.2.7, 1.2.12 and 1.7.11

Medication

NICE NG10 Recommendation 1.3.10

When prescribing p.r.n. medication as part of a strategy to de‑escalate or prevent situations that may lead to violence and aggression:

- do not prescribe p.r.n. medication routinely or automatically on admission
- tailor p.r.n. medication to individual need and include discussion with the service user if possible
- ensure there is clarity about the rationale and circumstances in which p.r.n. medication may be used and that these are included in the care plan
- ensure that the maximum daily dose is specified and does not inadvertently exceed the maximum daily dose stated in the British national formulary (BNF)

when combined with the person's standard dose or their dose for rapid tranquillisation

- only exceed the BNF maximum daily dose (including p.r.n. dose, the standard dose and dose for rapid tranquillisation) if this is planned to achieve an agreed therapeutic goal, documented, and carried out under the direction of a senior doctor
- ensure that the interval between p.r.n. doses is specified.

NICE NG10 Recommendation 1.3.11

The multidisciplinary team should review p.r.n. medication at least once a week and, if p.r.n. medication is to be continued, the rationale for its continuation should be included in the review. If p.r.n. medication has not been used since the last review, consider stopping it.

Psychological support

NICE NG10 Recommendation 1.2.7 (Partial extract)

Ensure that service users are offered appropriate psychological therapies, physical activities, leisure pursuits such as film clubs and reading or writing groups, and support for communication difficulties.

NICE NG10 Recommendation 1.2.12

Consider offering service users with a history of violence or aggression psychological help to develop greater self-control and techniques for self-soothing.

NICE NG10 Recommendation 1.7.11

Consider offering children and young people with a history of violence or aggression psychological help to develop greater self-control and techniques for self-soothing.

4.3.3 Current UK practice

No data on current practice was found related to medication and psychological support. This area is based on stakeholder’s knowledge and experience.

4.3.4 Resource impact assessment

No resource impact was anticipated from recommendations in this area of NG10. This is because it is considered that where clinical practice changes, as a result of the guidance, there will not be a significant change to resource impact.

4.4 Using restrictive interventions

4.4.1 Summary of suggestions

Physical health and monitoring of vital signs

Stakeholders highlighted the importance of ensuring that restrictive interventions are performed safely, with regard for physical health and with continued monitoring of vital signs.

Post-incident debrief and formal review

Stakeholders highlighted the importance of post-incident review to enable all involved to recover from the incident, review the individual's care and support wider organisational learning.

4.4.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are also presented in full underneath the table to help inform the committee's discussion.

Table 8 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Physical health and monitoring of vital signs	NICE NG10 Recommendations 1.4.3, 1.4.25. 1.4.32, 1.4.33 and 1.4.45
Post-incident debrief and formal review	NICE NG10 Recommendations 1.4.55 and 1.4.58

Physical health and monitoring of vital signs

NICE NG10 Recommendation 1.4.3

Health and social care provider organisations should ensure that resuscitation equipment is immediately available if restrictive interventions might be used and:

- include an automatic external defibrillator, a bag valve mask, oxygen, cannulas, intravenous fluids, suction and first-line resuscitation medications
- maintain equipment and check it every week.

NICE NG10 Recommendation 1.4.25

Do not use manual restraint in a way that interferes with the service user's airway, breathing or circulation, for example by applying pressure to the rib cage, neck or abdomen, or obstructing the mouth or nose.

NICE NG10 Recommendation 1.4.32

One staff member should lead throughout the use of manual restraint. This person should ensure that other staff members are:

- able to protect and support the service user's head and neck, if needed
- able to check that the service user's airway and breathing are not compromised
- able to monitor vital signs
- supported throughout the process.

NICE NG10 Recommendation 1.4.33

Monitor the service user's physical and psychological health for as long as clinically necessary after using manual restraint.

NICE NG10 Recommendation 1.4.45

After rapid tranquillisation, monitor side effects and the service user's pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every hour until there are no further concerns about their physical health status. Monitor every 15 minutes if the BNF maximum dose has been exceeded or the service user:

- appears to be asleep or sedated
- has taken illicit drugs or alcohol
- has a pre-existing physical health problem
- has experienced any harm as a result of any restrictive intervention.

Post-incident debrief and formal review Immediate post-incident debrief

NICE NG10 Recommendation 1.4.55

After using a restrictive intervention, and when the risks of harm have been contained, conduct an immediate post-incident debrief, including a nurse and a doctor, to identify and address physical harm to service users or staff, ongoing risks and the emotional impact on service users and staff, including witnesses.

NICE NG10 Recommendation 1.4.58

Ensure that the service user involved has the opportunity to discuss the incident in a supportive environment with a member of staff or an advocate or carer. Offer the service user the opportunity to write their perspective of the event in the notes.

4.4.3 Current UK practice

Post incident debrief and formal review

The Prescribing Observatory for Mental Health UK Is currently undertaking a prospective audit on rapid tranquilisation. The result will be disseminated in 2017.

Physical health and monitoring of vital signs

A 2012 audit in a UK secure psychiatric hospital[2], examined use of rapid tranquilisation in 35 patients over a one month period:

- In 5 cases pulse, blood pressure and respiratory rate were recorded.
- In 1 case a pulse oximeter was used
- In 2 cases it was documented that the patient refused monitoring.

A Mind review[3] examined the use of physical restraint in 51 mental health trusts in England in 2011-12. They reported large variation in the use of physical restraint, ranging from 38 incidents to 3346 (median 455). Similarly use of face down restraint varied across trusts, ranging from 0 incidents to 923 (median 65).

NHS England issued a patient safety alert in 2015[4], highlighting the importance of checking vital signs during and after restrictive interventions.

4.4.4 Upcoming data collection

The Prescribing Observatory for Mental Health UK is currently undertaking a prospective audit on rapid tranquilisation. The result will be disseminated in 2017, for further information see the POMH-UK programme pages.

[2] Haw et al (2012) A survey of the use of emergency parenteral medication at a secure psychiatric hospital. Journal of Psychiatric Intensive Care, vol 00.No0:1-8.
[3] Mind (2013) Mental health crisis care: physical restraint in crisis
[4] NHS England (2015) Patient safety alert – the importance of checking vital signs during and after restrictive interventions/manual restraint

4.4.5 Resource impact assessment

If health and social care provider organisations are not providing training in line with the guideline's recommendations, there may be additional costs to implement recommendations in this area of NG10.

The costing statement for NG10 identifies that there may be additional costs for staffing, when restrictive interventions are carried out. Additional staff may be needed to ensure that there are enough staff available at all times to work together as a team.

There should be staff trained in immediate life support and a doctor trained to use emergency equipment immediately available to attend an emergency if restrictive interventions (such as manual restraint) may be used. This may necessitate training for staff or recruiting additional trained staff, including doctors.

4.5 Working with the police

4.5.1 Summary of suggestions

Stakeholders suggested that health and social care organisations should have clear arrangements for joint working with the police. They highlighted lack of clarity around:

- when and how police should enter health/social care settings
- when and how health/social care professionals should enter police cells
- how to ensure safe and effective transfer of patients between settings

Stakeholders also highlighted conflicting advice between NHS and Police, a need for clarity around police response within psychiatric units and the legal implications of assaults within those settings.

4.5.2 Selected recommendations from development source

Table 9 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are also presented in full underneath the table to help inform the committee's discussion.

Table 9 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Working with the police	NICE NG10 Recommendation 1.1.13, 1.6.6

Working with the police

NICE NG10 – Recommendation 1.1.13

Health and social care provider organisations should work with the police, and local service user groups if possible, to develop policies for joint working and locally agreed operating protocols that cover:

- when and how police enter health or social care settings (including psychiatric and forensic inpatients, emergency departments, general health inpatients, GP surgeries, social care and community settings and 136 place-of-safety suites)
- when and how health and social care professionals enter police cells

- transferring service users between settings.

Review the operating protocols regularly to ensure compliance with the policies and update the policies in light of operational experience.

Managing violence and aggression

NICE NG10 – Recommendation 1.6.6

Community mental health teams should not use manual restraint in community settings. In situations of medium risk, staff should consider using breakaway techniques and de-escalation. In situations of high risk, staff should remove themselves from the situation and, if there is immediate risk to life, contact the police.

4.5.3 Current UK practice

A Mind review[5] examined the use of physical restraint in 51 mental health trusts in England in 2011-12. They reported significant variation in the numbers of recorded incidents where police were called. In 2011-2012, one trust reported 100 incidents whereas 3 trusts reported not having to call the police at all.

4.5.4 Resource impact assessment

No resource impact was anticipated from recommendations in this area of NG10. This is because it is considered that where clinical practice changes, as a result of the guidance, there will not be a significant change to resource impact.

[5] Mind (2013) Mental health crisis care: physical restraint in crisis

4.6 Additional areas

Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or require further discussion by the committee to establish potential for statement development.

There will be an opportunity for the committee to discuss these areas at the end of the session on 16th November 2016.

Management of Acute Behavioural Disturbance (ABD) within ED

Stakeholders suggested that Management of Acute Behavioural Disturbance (ABD) within ED should be prioritised as an area for quality improvement. This quality standard covers short-term management of all violent and aggressive behaviour in adults, children and young people with a mental health problem and wouldn't distinguish ABD within the emergency departments as a separate area.

Mental health in prisons

Stakeholders highlighted increasing violence, self-harm and access to resources within the prison population as an area for quality improvement. These are areas out of the scope of this quality standard, addressing wider issues of health and violence in prisons. Separate guidance and quality standards are in development on the physical and mental wellbeing of people in prison.

Monitoring compliance

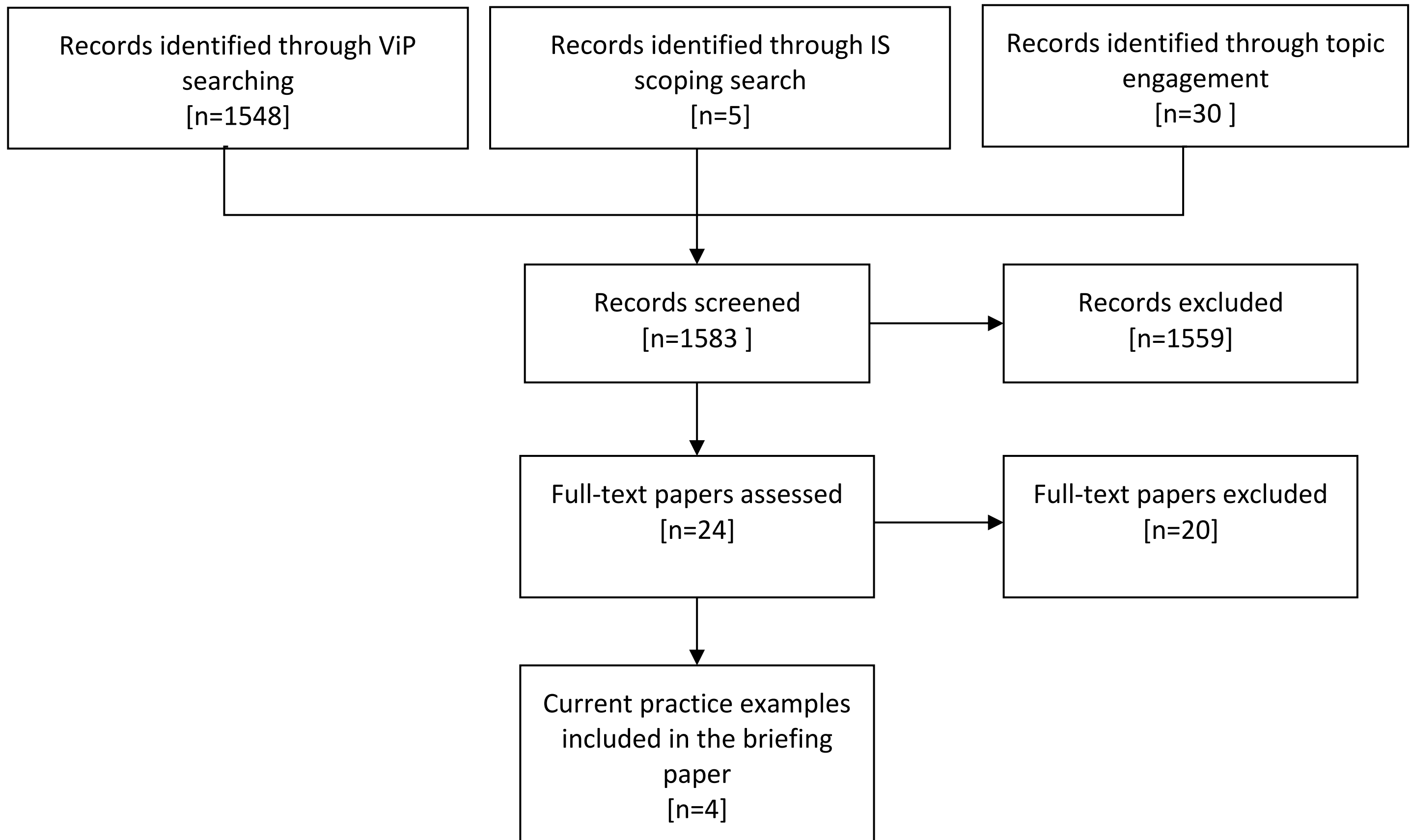
Stakeholders suggested that monitoring compliance with the guideline in CAHMS as an area for quality improvement. Monitoring compliance with the guidelines is not the focus of quality standards.

Staff training

Stakeholders made a range of suggestions around identifying effective staff training and different types of training needed. They also suggested that paramedics, emergency department staff and mental health staff are the groups that should be prioritised for the training.

Staff training and competencies are not usually within the remit of quality standards as these should be read in the context of national and local guidelines on training and competencies. NICE has endorsed a training manual produced by West London Mental Health Trust – Broadmoor Hospital, which can be referenced to help support the final quality standard.

Appendix 1: Review flowchart



Appendix 2: Suggestions from stakeholder engagement exercise – registered stakeholders

ID	Section	Stakeholder	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
1	4.1	SCM2	Early and timely assessment of behaviour to reduce the escalation of that behaviour to violence/aggression.	There is some low level emerging evidence which was cited in NG10 that the use of a structured risk assessment (prediction instrument) is superior to unstructured clinical judgement. It is important to risk assessment is focussed on assessing the risk of likely violence/aggression in the short-term, and appropriate risk management plans are created for the short-term and implemented in the short-term.	It is reasonably well know that in the UK there is a variation in practice in this area. Some clinical environments continue to use unstructured clinical judgment, some use risk assessment tools which may or may not be evidenced-based in relation to the short-term assessment and management of violence and aggression.	The supporting information is that from NG10.

2	4.1	Surrey and Borders Partnership NHS Foundation Trust	Dilemmas faced for staff when they experience abuse	I think it would be important to think about the dilemmas faced for staff when they experience abuse and to disentangle how best to respond when someone has good/little insight into this. So much more work is needed to help staff to reflect on why this happens and to formulate reasons why and develop care plans.		

3	4.1	SCM2	Patients who are likely to present with violence/aggression or patients who have presented with violence/aggression should have a nursing/medical careplan which characterises the presentation (triggers and characteristics) and the management strategies.	As far as I am aware, this has been a focus of CQC inspections and the Positive and Safe workstream from the Department of Health. The violence and aggression referred to in NG10 is that associated with adults and young people in health and social care settings, in the context of a mental disorder. As such the violence/aggression should be treated like any other vulnerability/symptom, and needs a multidisciplinary careplan.	The careplan should: 1. Have the input of patients and carers. 2. Should be written with regard to the legal frameworks, e.g. the MHA Code of Practice and with regards to the principle of least restriction. 3. Should be individualised and not “blanket”. 4. Should be “owned” by a clinician who is responsible for the day to day direct assessment and management of the patient, e.g. a primary nurse in the acute inpatient setting. 5. Should be in a format which is recognisable as a careplan (in that it should form part of the array of careplans for the patient, e.g. alongside a physical health careplan. 6. Should be made available to and agreed with the patient, as far as is practicable. 7. Should be reviewed on a regular basis, e.g. every day in a psychiatric intensive care unit; or as minimum at any timepoint where there is a material change in the risk assessment. 8. Should have a greater degree of scrutiny and details for more restrictive interventions.	The associated information which may be of benefit includes: 1. MHA Code of Practice. 2. Positive and Safe; Positive and Proactive Care; Department of Health. 3. CQC Inspection Framework Documents.
4	4.1	SCM4	A non-custodial approach to mental health nursing.			

5	4.1	NHS Protect	Additional developmental areas of emergent practice: National standard for the prevention of challenging behaviour though the creation of a therapeutic environment.	Over five years there has been a consistent reporting to NHS Protect of physical assaults which include medical factors. These are reported incidents where the NHS organisation makes a judgement that the person did not known what they were doing or know what they were doing was wrong due to mental ill health, a learning disability or treatment being received or administered.	NHS Protect's (2015) annual Reported physical assaults on NHS staff in 2014-15 in the mental health sector, highlights that 78% of all incidents of assaults in England are deemed to include medical factors.	In 2013-14 NHS Protect launched the national work programme on work to prevent and manage clinically related challenging behaviour: Meeting needs and reducing distress: www.reducingdistress/reducingdistress.co.uk In 2016 NHS Protect evaluated its work programme to assess if the guidance, website and training videos had helped NHS organisations tackle challenging behaviour. Almost three quarters (73%) of respondents surveyed who were able to answer said that their organisation had fully or partially implemented NHS Protect's guidance and tools and over half (57%) found the guidance and tools to be extremely or very helpful. The work programme particularly led to highly improved or improved organisational culture (58%), person centred care (56%), staff and patient safety (54%), and the provision of

						extra training (49%) in organisations that responded. NHS Protect also evaluated Meeting Need and Reducing Distress website as a powerful resource to assist NHS staff tackle challenging behaviour. The Meeting Needs and Reducing Distress website site attracted over 18,000 unique users and 57,000 page views in year one (2014) and over 27,000 unique users and nearly 60,000 page views in year two (2015), indicating a sustained interest in the site. There is a further need to include this work as best practice in this quality standard.
6	4.1	RCN	Implementation of evidence based ward routines	NICE guidelines NG10 recognise that mental health wards can be challenging environments	Evidence from the NICE guideline indicates that a number of specific ward routines are associated with reductions in violence or restrictive practices. Implementation of evidence based ward routines would help to reduce violence and restrictive practices and support high quality support and service for patients and staff.	NICE NG10: Violence and aggression: short-term management in mental health, health and community settings

7	4.1	NCD for secure MH	Environmental standards	Environments and healthy ward communities that may mitigate or prevent violence and aggression – e.g. noise levels, building design, lighting, low-stimulus calming facilities e.g. comfort room models, access to fresh air, privacy, family and friends and meaningful activity etc. access to fresh air.		
8	4.1	SCM3	Environments and cultures that precipitate conflict	There is significant evidence to suggest that the environment both organisationally and environmentally can lead to or prevent aggression	Environments are complex and inherently problematic across a range of social and health care settings and communities.	

9	4.2	Mind	Staff communication and interactions with patients	The quality of staff communication and interaction with patients is central to therapeutic care, primary prevention of violence and aggression, de-escalation, minimising the distress of restrictive interventions and enabling recovery from a restrictive intervention	The guideline promotes staff emotional regulation and self-management. In our consultations with people who have experience of being restrained we have heard about some very negative experiences of staff behaviour leading up to and following restraint as well as during incidents. These include poor communication, powerful non-verbal communication, avoidable escalation, verbal put-downs and threats, and over-anticipation of violence. Follow-up communication and debrief is often lacking. There will be other, more positive experience, particularly where use of restrictive interventions is being successfully reduced, but the persistence of such experiences suggests this is an important area for quality improvement.	Please see our 2013 campaign report and 2016 campaigner guide (in particular pages 12-16). The top line findings of a more recent survey by the National Survivor User Network are included in this blog, and the blog author's own experience powerfully illustrates the need for improvements in practice. Safewards is a well-recognised approach to reducing conflict and improving interactions in inpatient settings. Promise is a quality improvement programme started in Cambridge and part of a global partnership, aiming to eliminate reliance on force in mental health care. The link above is to some of the many initiatives made by frontline staff to improve inpatient experiences.

10	4.2	SCM3	Staff attitudes about violent patients	There is growing evidence that relationships between patients and staff are crucial and that negative attitudes can effect care	Increasingly it is reported that negative staff and patient relationships can lead to aggression and violence. Ways of addressing this individually and culturally are needed	
11	4.2	SCM3	Prevention and De-escalation	There is good evidence that this is key in preventing violence in the first place, however more work is needed on de-escalation	De-escalation is embedded in all aggression and violence causes yet little is known about what this means or how to implement it as part of an overall continuum of prevention at different staged=s of the assault cycle	Safewards.net website

12	4.2	NHS Protect	National standard for Positive Behavioural Support and de-escalation of challenging behaviour.	Staff should be competent in de-escalation, necessitating that restraint should only ever be used as a last resort when de-escalation is not working. This is in line with the Department of Health's (DH) (2014) Positive and Proactive Care: Reducing the need for restrictive interventions.	The current evidence suggests that de-escalation is not done particularly well or is effective especially in managing violence and aggression in mental health settings. See Review in British Journal of Psychiatry, June 2015. This should be followed by a comprehensive literature review.	The DH is developing national guidance for de-escalation training with defined learning outcomes which will form the national standard in de-escalation and this is pencilled in for delivery at the end of this year. The emphasis of the standards will be on prevention through Positive Behavioural Support and good de-escalation in mental health and learning disability settings. The DH are also looking at a framework for accreditation of training and are considering various models, such as that operated by BILD. Further details: contact Guy Cross: guy.cross@dh.gsi.gov.uk .
13	4.2	SCM3	Service user decision making regarding care	There is a plethora of evidence that this is crucial at all stages of the preveintion and management of aggression	There are clear drivers for this but ways of implementing are needed	

14	4.2	SCM3	Minimising restrictive interventions	There is excellent evidence and policy guidance to support this as a priority	There is growing evidence that approaches to minimising restrictive practices are needed at organisational levels	REsTRAIN YOURSELF toolkit/website TBC MOJ Restraint related deaths document 2011
15	4.2	Mind	Restrictive intervention reduction programmes	Concerted, organisation-wide programmes to reduce restrictive interventions are a central implementation tool for much of what is contained in the guideline	There has been a lot of activity, over the last two years in particular, to reduce restraint, and numerous organisations and individuals are championing restraint reduction (eg through the Positive and Safe champions network, the Restraint Reduction Network, through campaigners pushing their local trusts to implement changes). However this is not universal, it takes time to embed, and there is still a lot to learn from organisations that are taking the lead. Much of their work is in trial or pilot sites and not yet across the board.	
16	4.2	NCD for secure MH	Conflict and restraint reduction strategies	It would be useful to explore the relationship between the use of restrictive practice and the management of violence and aggression – asking the question 'How effective are interventions to reduce restrictive practices in improving quality and clinical outcomes in managing violence and aggression?'	It would be helpful for the quality standard to highlight the effective components of the core themes in these programmes relating to: leadership and culture; service user involvement; governance and monitoring; workforce development and training; review and learning processes. Many services have implemented such programmes following recent national guidance in this area and it would be useful to examine the clinical outcomes and data set in relation to the efficacy of these approaches.	

17	4.2	SCM1	CAMHS should have a clear and consistent enforced policy about managing antisocial behaviour and ensure that staff are trained in psychosocial and behavioural techniques for managing this behaviour	The NICE guideline has outlined techniques for managing antisocial behaviour, violence and aggression in CAMHS users. It is however unclear how widespread and enforced are clear and consistent policies and staff training in this area	It is highly likely that individual programmes differ in the extent to which working policies and training are available for CAMHS staff.	
18	4.3	SCM4	Reliance on medication	Reliance on medication, some of which have nasty side effects [even fatalities] should be reduced.		
19	4.3	SCM4	Psychological input	Psychological input (although expensive) should be increased which will improve the mental well being of the patient and help him recover.		
20	4.3	SCM4	Psychotherapy	Psychotherapy can reduce violence and aggression – this applies to some nursing staff also– remember Winterbourne ?		

21	4.4	NHS Protect	National standard for physical restraint.	Under the DH Positive and Safe, the responsibility is for organisations to have clear strategies in place for restraint intervention and reduction.	The available evidence would tend to suggest that physical interventions are still used far too frequently to manage a challenging situation. It is problematic that through the work of DH Positive and Safe, organisations should plan to reduce restrictive interventions when there is no standard as to what actually constitutes safe/unsafe restrictive interventions.	There is a need for a specific national standard on physical restraint which we as an organisation are repeatedly asked for. The DH work (above) will cover elements of physical interventions such as the use of pain compliance, prone restraint and the threshold for calling the police and their involvement which necessitate physical intervention skills being used. However this will not form a national standard for the use of restraint. Similarly, NICE guidelines NG10 (2015) Violence and aggression: short term management in mental health, health and community only sets the context for when restraint may be considered and highlights good practice in this area. There is a clear need for NICE to demonstrate clear leadership on developing a national standard for physical restraint for clinical situations.

22	4.4	Mind	Learning from data	Use of data is an important part of restraint reduction strategies	We welcome the improvements that are being made in data collection around restraint. We are concerned that this should be the most meaningful and helpful information possible and so it is important that records/reports include: • antecedents to the incident (to assist in preventing future restrictions) • positive outcomes of changes made (not only counting the negatives – incidents and harms – though these are essential as well) • perspectives of the person subject to the restriction wherever possible	
23	4.4	Mind	Understanding the impact of trauma	While restraint and other restrictive interventions can be traumatic for anyone, they can re-traumatise people with past experience of physical or sexual abuse. Understanding the impact of trauma is therefore important in person-centred care, reducing the need to use restrictions, how restrictive interventions are carried out and how people are supported afterwards	In the focus groups for our restraint guides we heard about individuals' experiences that were clearly not trauma-informed, and the practice of asking people about previous experience of violence and abuse appears not to be embedded despite guidelines on this (see next column).	In a recent FOI investigation by Agenda about mental health services for women, half the trusts that responded had no policy on routine enquiry on past experience of violence and abuse.

24	4.4	NCD for secure MH	Duty of candour	Duty of Candour processes that facilitate professionals' and organisations demonstrating of openness after episodes of violence and aggression may be beneficial in terms of learning and engagement through greater transparency. These practices have been shown to be particularly effective in Healthcare in the United States.		
25	4.4	RCN	Post-incident debrief and review	There is good evidence that patient's experience in mental health settings impacts on their future engagement with care. Learning from service users' experience can improve the future quality of service provided to patients.	A patient's first experience of mental health settings can determine their future engagement with care. Service users describe the experience of restrictive practices as traumatising.	Day, J.C., Bentall, R.P., Roberts, C., Randall, F., Rogers, A., Cattell, D., Healy, D., Rae, P., Power, C., 2005. Attitudes Toward Antipsychotic Medication: The Impact of Clinical Variables and Relationships With Health Professionals. Arch Gen Psychiatry 62, 717–724. doi:10.1001/archpsyc.62.7.717

26	4.4	Mind	Learning from people’s experience through post-incident feedback or review	Post-incident feedback and review is important for enabling all involved to recover from the incident, reviewing the individual’s care and wider organisational learning. It is important that this involves the person who was subject to the intervention, to the extent that they wish. This is central to understanding what led up to the incident, what could have been done differently, how the intervention impacted on the person and what could be done differently in future.	Although involvement of the person is fully recognised in guidance (Department of Health, Mental Health Act Code of Practice and NICE) this appears to be something that organisations struggle with, and can get wrong (eg in the focus groups we carried out for our restraint guides people told us about debrief happening at the wrong time for them or feeling as though they were being told off – though mostly they said it did not happen). Staff are also concerned about not retraumatising patients. Prioritising how to do this in a sensitive way would therefore be very helpful.	In NSUN's survey 81 per cent of people had no follow-up communication or debrief.

27	4.4	SCM2	A specific QI area should focus on the practice of RT alone.	The evidence base is patchy and pragmatism seems to prevail often in clinical practice. When done poorly, this can be a high risk medical intervention In my opinion, during RT and post-RT physical health monitoring should have the profile akin to "during and after a medical emergency".	During and Post RT Physical Health Monitoring.	As cited in NG10.
28	4.4	SCM2	Every time certain restrictive interventions are used in a patient's care, there are steps which should be taken.	The restrictive interventions which are more relevant in this respect, include: 1. Enhanced psychiatric observation and monitoring. 2. Physical Restraint. 3. RT (intramuscular). 4. Seclusion. 5. Combinations of the above. In such restrictive interventions, it is important to dynamically assess the following areas: 1. The rationale for the	This is a key area for QI as it should form the cornerstone of most organisations' violence reduction strategies. The work over the past few years in the Department of Health's Positive and Safe workstreams has focussed on these (and many other) themes. I am aware that the Department of Health and NHS Benchmarking have sought to collect basic data in the area of restrictive interventions (it should be possible to ask for the data). I am also aware that POMH-UK has been collecting data related to PRN and RT prescribing. Many of the areas cited in this QI, are linked to organisational and staff training needs. Examples include training for	The associated information which may be of benefit includes: 1. Positive and Safe; Positive and Proactive Care; Department of Health. 2. POMH-UK data. 3. Positive and Safe Violence Reduction and Management Programme (endorsed by NICE) – see link. https://www.nice.org.uk/guidance/ng10/resources/endorsed-resource-positive-and-safe-violence-reduction-and-management-programme-instructors-manual-2600289181

				use of the restrictive intervention. 2. The safety monitoring of the restrictive intervention for the patient and staff (during the restrictive intervention). 3. The efficacy of the restrictive intervention for the patient's presenting condition. 4. Whether a debrief occurred for the patient and staff post restrictive intervention. 5. The safety monitoring of the restrictive intervention for the patient and staff (following on from the restrictive intervention). 6. The recording of safety incidents and the systemic learning from these.	physical restraint and debrief. This is an area that is currently getting some coverage at a "national" level.	

29	4.4	NHS Improvement (national patient safety team)	Whilst we would accept the key focus of the QS is to avoid V&A, we would hope the safety aspects of when and if restrictive intervention is used, this is done as safely as possible, should be included	Evidence of death and severe harm – see https://www.england.nhs.uk/2015/12/psa-vital-signs-restrictive-interventions/	We identified inconsistent practice, especially a risk that the safety precautions taken during active restraint were not continued in the following period when patients remain vulnerable to collapse or death	Please see the NHS England Patient safety alert – The importance of checking vital signs during and after restrictive interventions/manual restraint at https://www.england.nhs.uk/2015/12/psa-vital-signs-restrictive-interventions/
30	4.4	NCD for secure MH	Support and debriefing	Relating to individuals who are involved in episodes of violence and aggression it would be beneficial to outline which specific strategies are effective in supporting people who have been assaulted. In particular which are the important aspects of debriefing approaches for service users and staff (including those who may be affected by witnessing assaults). Further understanding of the support mechanisms implemented in services which reduce harm both to patients and staff e.g.		

				individual support, community/ mutual help meetings, supervision and reflective practice to address the issues which arise. A particular challenge for services in implementing NG10 has been the operationalisation of external 'service user experience monitoring units' to conduct formal reviews.		
31	4.5	Hampshire Constabulary	Management of violence within a psychiatric in-patient unit	There is a pressing need to reduce reliance on Police response and intervention	The imminent publication of the Carlile Inquiry into use of Police restraint is going to dramatically reduce Police involvement to those occasions only where life is immediately at risk	This is due to be released in the next few days and I can forward a link at that point.
32	4.5	SCM2	Health and Social Care provider organisations should have policies for joint working with the police.	This is well cited in NG10.	There is sometimes divergence of opinion or lack of clarity around: 1. When and how police should enter health/social care settings. 2. When and how health/social care professionals should enter police cells. 3. How to ensure safe and effective transfer of patients between settings. (all in the context of managing violence/aggression associated with mental disorder).	Please see link: http://www.college.police.uk/News/College-news/Pages/mental_health_consultation.aspx

33	4.5	Hampshire Constabulary	Ensure the guidance is clear and for all.	There is currently conflicting advice between NHS and Police service. For example “Positive and Proactive Care” gives clear guidance around minimising use of restraint and pain compliance in a hospital setting, but then states it does not apply to Police. Police guidance is that any restraint will be clinically led. Police officers are ONLY trained in pain compliance restraint	We need to be clear on what is a safe option, and available to all; and then what is not safe, and should not be used by anyone within a hospital. It needs to be clear that clinical staff will lead any intervention and be responsible for the Health and Safety of the patient. It needs to understand that Police tactics and techniques will rely on pain compliance if used without clear clinical guidance.	

34	4.5	NHS Protect	National standard for a police response to incidents in MH settings.	Where an incident unfolds, there is often no clear assessment of risk for when the police should be called or accepted principles for a police response on NHS premises.	NHS Protect’s (2016) report A Five Year Analysis of Physical Assaults against NHS staff in England SIRS/RPA Violence Report 2010-2015 based on 33,123 reported incidents of assault in mental health settings, victims wished to report incidents to the police in only 2.8% of cases, in 7.2 % of cases the incident was reported to the police, in 4.4% of cases the police attended in 1.2 % a sanction was achieved.	The Lord Carlile/College of Policing ERG are developing guidance for the police and NHS on the police role and use of restraint in mental health premises. This guidance will include a threshold for when the police should be called and are expected to attend on mental health premises and the role of police in supporting NHS staff in restraint situations. This work is scheduled to be completed towards the end of 2016 and will form part of the local NHS Concordat action plans.

35	4.5	NHS Protect	National standard for prosecutions in the mental health sector.	Following an incident, there are often difficulties in the mental health sector particularly around the provision of sufficient evidence of an individual's capacity and criminal intent. This may either mean that, based on the available evidence, the CPS decide that a prosecution is not in the public interest, or that a prosecution does not result in a conviction.	NHS Protect's (2016) report: Five Year Analysis of Physical Assaults against NHS Staff in England 2010-2015, based on 33,123 reported incidents of assault in mental health settings, victims wished to report incidents to the police in only 2.8% of cases, in 7.2 % of cases the incident was reported to the police, in 4.4% of cases the police attended in 1.2% a sanction was achieved. NHS Protect's quality assessment against its Standard 4.2 which measures an organisation's commitment to apply all appropriate sanctions against those who commit crime, shows a low level of compliance with this standard. We can provide more evidence from inspections if necessary.	NHS Protect is developing with the National Police Chief's Council (NPCC) a National partnership protocol for managing risk and investigating crime in mental health settings. This is due for launch at the end of 2016. This protocol will provide a basis for, or to review, local agreements for the investigation and prosecution of crime in mental health settings.
36	4.5	Hampshire Constabulary	Management of aggression in a care home type environment, particularly with regards to children and the elderly	Care home managers have obligations under Health and Safety legislation to ensure their staff are trained and equipped to manage foreseeable situations. This is in addition to other legislation such as the Care Act and Childrens Act etc	The impact of the Carlile review is also going to impact upon care settings, particularly those with children with behavioural issues or those caring for the elderly with dementia or similar. Staff need to be able to manage disruptive or agitated behaviour and not rely on Police intervention	Sections 2, 3 and 7 of the Health and Safety at Work Act 1974 http://www.legislation.gov.uk/ukpga/1974/37/contents Regulations 3 and 5 of the Mangement of Health and Safety at Work Regulations 1999 http://www.legislation.gov.uk/uksi/1999/3242/contents/made

37	4.6	RCN	Team Leadership	There is good evidence suggesting that leadership and good team working improve patient and staff safety.	Evidence from the Kings fund (Michael West) and NIHR Service Delivery and Organisation programme shows that the qualities of good leadership are associated with improved team working, improved staff morale, engagement with work and improved safety.	Johnson et al (2011) Inpatient Mental Health Staff Morale: a National Investigation http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1604-142_V01.pdf Michael A. West , Joanne Lyubovnikova , Regina Eckert , Jean-Louis Denis , (2014) "Collective leadership for cultures of high quality health care", Journal of Organizational Effectiveness: People and Performance, Vol. 1 Iss: 3, pp.240 - 260
38	4.6	RCGP	Self-inflicted deaths in the prison setting	Increasing number of self-inflicted deaths over the last few years.	Suicide and self-harm are both increasing in the prison setting.	Prison and Probation Ombudsman Annual Report 2015 - 2016
39	4.6	RCGP	Violence in the prison setting	Large increase in prison violence over the last year.	Assaults on both prisoners and staff.	Her Majesty's Inspector of Prisons (HMIP) Annual Report 2015 - 2016

40	4.6	RCGP	Improved access to appropriate resources to address mental health needs of prisoners to reduce self-harm and suicide	Statistics and research in this field is sparse.		It is important that this patient group is not overlooked. Prisons are effectively part of the community with patients entering these environments and being released back to communities. It is important their needs are not overlooked and that we address the rise in self-harm, suicide and violence. Schemes such as Liaison and Diversion may also play a part in improving access to pathways thus avoiding a custodial sentence and improving the continuity and quality of mental health provision. Overall reduction in recidivism if needs are appropriately addressed. The RCGP is aware of the impending NICE Guideline on Mental Health of Adults in Contact with Criminal Justice System – it is important that there is no ‘disconnect’ between these two pieces of work.

41	4.6	SCM5	Impact on children	Including the management of children in this guideline is a welcomed advance to the original guideline (CG 25). As this is new and includes the use of drugs and physical intervention, I believe that it is important to monitor compliance, rate, safety and efficacy of drug, behavioural and physical interventions.		

42	4.6	SCM5	Training efficacy	There remains no national consensus on training approaches for staff managing violence and aggression. There are some national leaders but individual training providers are largely unregulated and offer a wide array of training interventions compiled without analysis or consideration of what staff and service users need in practise. It is therefore important to monitor the efficacy and safety of interventions used in practise. There therefore needs to be a reporting and monitoring system (such as used by the police) for any use of force. This will guide training needs analysis for each and every organisation (ED, secure units, children etc).	City and Guilds, NFPS, GSA are among those offering guidance in this respect.	
43	4.6	SCM5	Training needs analysis	See above		

44	4.6	NCD for secure MH	Standards of training	Clarity about the knowledge base, competency and skills required by the workforce to enable them to prevent and manage violence and aggression, specifically in settings that may be harder to access e.g. secure settings. In particular, the effective components of workforce training in relation to values based approaches, primary prevention strategies and de-escalation practices to reduce aggression.		

45	4.6	NHS Protect	National standard for prevention and management of violence and aggression training and challenging behaviour awareness training.	The NHS Standard Contract includes mandatory clauses that require providers of NHS services to put in place and maintain appropriate security management arrangements to ensure a safe and secure environment. The clauses require providers to take a risk based approach to security management requiring providers to carry out a risk assessment following NHS Protect's Standards for NHS providers. NHS Protect's Security Standard for providers 3.1 requires 'the organisation to risk assess job roles and undertakes training needs analyses for all employees, contractors and volunteers whose work brings them into contact with NHS patients and members of the public. As a result, the level of training on prevention of	NHS Protect has in place a quality assurance programme to enable NHS providers to review their security provision, and as part of this process, based on NHS Protect's review, where concerns are raised, we may assess an NHS organisation's compliance to meet these standards. Feedback from NHS Protect's quality inspections where they relate to standards 3.1 and 3.2 suggest that NHS organisations are not particularly good at conducting a risk based approach to the provision and delivery of prevention and management of violence and aggression training and training in challenging behaviour. We can provide more evidence of this if required.	NHS Protect (2013) has issued national guidance on conflict resolution training. There is an internal group which is currently updating our Conflict Resolution Training guidance for the NHS, which is based on a risk based training model. The guidance is due for completion by April 2017. See: http://www.nhsbsa.nhs.uk/Documents/SecurityManagement/Conflict_resolution_training_guidance_July_2013.pdf NHS Protect (2013) has issued guidance on clinically related challenging behaviour, Meeting needs and reducing distress: Guidance on the prevention and management of clinically related challenging behaviour in NHS settings. This guidance refers to a risk based approach to the provision of challenging behaviour awareness training. See:

				violence and aggression is monitored, reviewed, delivered and evaluated for effectiveness in accordance with NHS Protect's guidance on conflict resolution training' NHS Protect's Security Standards for providers 3.2 requires 'the organisation ensures that staff whose work brings them into contact with NHS patients are trained in the prevention and management of clinically related challenging behaviour, in accordance with NHS Protect's guidance. Training is monitored, reviewed and evaluated for effectiveness.'		http://www.nhsprotect.nhs.uk/reducingdistress/

46	4.6	RCN	Staff training in least restrictive practices	NICE Guidelines NG10 and Quality Standard 14 both acknowledge that staff are subject to unacceptable levels of violence and aggression whilst doing their work. The standards also recommend using service users to monitor and improve services.	NHS protect data on the reported incidence of violence and aggression is a problem for paramedics, emergency department staff and mental health staff. Training for these groups is a priority. Certain patient groups are more at risk of harm or death from physical restraint. Staff should have a good knowledge and understanding of the risks so that they can plan appropriate interventions. Using service users to inform staff about their experiences of care should form part of any training programme.	NICE NG10: Violence and aggression: short-term management in mental health, health and community settings NICE Quality standard 14: Service user experience in adult mental health services Quality statement 5: Using views of service users to monitor and improve services
47	4.6	SCM4	Staff training	All staff – regardless of grade - who come into contact with mentally ill patients should have had adequate psychological training. This will help patient-nurse relationship		
48	4.6	SCM3	Any developmental areas of emergent practice	6 Core strategies	Organisational models to minimise conflict and containment are growing	Papers on Six Core Strategies// REsTRAIN YOURSELF Safewards and No force First
49	4.7 (other)	Hampshire Constabulary	Management of Acute Behavioural Disturbance (ABD) within ED	An increasing number of people are now being taken to ED with disturbed or psychotic behaviour where previously they would	People who are in ABD are at significant risk of death, particularly if under physical restraint. Due to recent high profile investigations into some deaths under Police restraint, Police officers nationally are now bringing most disturbed people to ED.	There is long standing Police guidance on the management of ABD from the College of Policing – see para 3.7 here : https://www.app.college.police.uk/app-

				have been taken to a Police cell.		content/detention-and-custody-2/risk-assessment/#acute-behavioural-disturbance There is also recent guidance from the Royal College of Emergency Medicine and the Royal College of Physicians here : http://fflm.ac.uk/publications/guidelines-for-the-management-of-excited-deliriumacute-behavioural-disturbance/ Ongoing high profile examples http://www.bbc.co.uk/news/uk-england-birmingham-37175449 https://www.theguardian.com/uk-news/2016/sep/15/sean-rigg-cps-rules-out-charges-police-officers-death-in-custody https://www.theguardian.com/uk-news/2016/feb/01/two-police-officers-face-possible-charges-over-the-death-of-a-man-in-custody
50	4.7 (other)	Department of Health	No comments			

51	4.7 (other)	Royal College of Paediatrics and Child Health	No comments			
52	4.7 (other)	Surrey and Borders Partnership NHS Foundation Trust	Overlaps with other work	I think that the NICE guidance on this topic needs to be woven in with the work around the Positive and Safe agenda/ Positive Behaviour Support ideas as there is a real overlap to consider.		