NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Violence and aggression

Date of quality standards advisory committee post-consultation meeting:
22 March 2017

2 Introduction

The draft quality standard for violence and aggression was made available on the NICE website for a 4-week public consultation period between 24 January and 20 February 2017. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 16 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1 and 2.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

4. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

Stakeholders were also invited to respond to the following statement specific questions:

5. For draft quality statements 1 and 2: Draft quality statements 1 and 2 cover people in contact with mental health services. Do you think these statements could apply to people with a mental health problem using other types of services? If so, please describe the setting, the type of service and how the statements could be measured.

6. For draft quality statement 3: Should monitoring of physical health during and after manual restraint include more than monitoring pulse, respiration and complexion?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- General support for the QS and the areas prioritised
- Concern that the quality standard excludes people with learning disabilities
- Concern that violent and aggressive behaviour should not overshadow the person.
- Questioned some of the outcome measures for example staff injury rates.

Consultation comments on data collection

- Additional suggestions on national data reporting and collection via NHS benchmarking
- For statements 1 and 2 stakeholders suggested using the Security Incident Reporting System which records incidents of physical assault and indicators of escalation, such as accompanying non-physical abuse, theft and criminal damage.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

People in contact with mental health services who have been violent or aggressive are involved in identifying their triggers and early warning signs.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Suggestion that the identification of triggers and early warning signs should inform care planning, organisational culture and practice.
- Preventive interventions should be made more prominent
- Potential cost savings perceived if the violence and aggression is reduced – reduction in staffing levels, reduction in staff sickness absence

Consultation question 5 *For draft quality statements 1 and 2: Draft quality statements 1 and 2 cover people in contact with mental health services. Do you think these statements could apply to people with a mental health problem using other types of services? If so, please describe the setting, the type of service and how the statements could be measured.*

Stakeholders made the following comments in relation to consultation question 5:

- Statement should apply to all health services, not just mental health services
- Statement could cover other areas such as primary care, some acute care environments, local authority and voluntary sector, prisons and non-NHS secure settings for children and young people such as secure children's homes, secure training centres and young offender institutions
- Concern raised that it may be discriminatory to associate violence and aggression with users of the service who have mental health problems and not others
- Identifying people's needs and risks should apply to everyone using a service.

5.2 Draft statement 2

People in contact with mental health services who have been violent or aggressive are involved in identifying successful de-escalation techniques and make advance statements about the use of restrictive interventions.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- Suggestion that contextual aspect of violent behaviour needs to be considered while planning care – environmental and staffing issues need to be recognised as contributing factors
- Suggestion for de-escalation passport which would facilitate information sharing between health and care organisations
- Suggestion that service users should be involved in developing preventive as well as coping strategies at this point
- Concern that focusing on de-escalation techniques that had been used may limit the use of more progressive techniques

Consultation question 5 *For draft quality statements 1 and 2: Draft quality statements 1 and 2 cover people in contact with mental health services. Do you think these statements could apply to people with a mental health problem using other types of services? If so, please describe the setting, the type of service and how the statements could be measured.*

Stakeholders made the following comments in relation to consultation question 5:

- Statement should talk about all health services, not just mental health services
- Statement could cover other areas such as primary care, some acute care environments, local authority and voluntary sector, prisons and non-NHS secure settings for children and young people such as secure children's homes, secure training centres and young offender institutions
- Concern raised that it may be discriminatory to associate violence and aggression with users of the service who have mental health problems and not others
- Identifying people's needs and risks should apply to everyone using a service.

5.3 Draft statement 3

People with a mental health problem who are manually restrained have their physical health monitored during and after restraint.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Concerns that the recording of evidence for physical health monitoring during restraint would be difficult – using equipment, collecting data and results is difficult when the violent behaviour is taking place
- Concerns that results would not be meaningful due to physical exertion
- Stakeholders suggested the statement should focus on:
  - minimising the duration of restraint
  - monitoring only in the case of prolonged restraint
- Suggestion that minimum physical health standards need to be agreed to allow for data monitoring
- Trauma and psychological harm should be addressed alongside physical harm

Consultation question 6 *For draft quality statement 3: Should monitoring of physical health during and after manual restraint include more than monitoring pulse, respiration and complexion?*

Stakeholders made the following comments in relation to consultation question 5:

- Monitoring should cover physical observation in line with NEWS - National Early Warning Scores (respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate, level of consciousness)
- Using devices such as pulse oximetry for monitoring vital signs was suggested
- Suggestion that additional observations may need to be carried out depending on service users physical health or pre-existing health issues

5.4 Draft statement 4

People with a mental health problem who are given rapid tranquillisation have side effects, vital signs, hydration level and consciousness monitored after any rapid tranquillisation.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Need to define vital signs – due to the circumstances, monitoring of 'vital signs' may be limited to external observations of respiratory rate, hydration, and level of consciousness
- Definition of rapid tranquilisation questioned – discrepancies between NG10 and the Mental Health Act code of practice highlighted
- Need for developing clinical recording and incident system to allow appropriate monitoring after rapid tranquilisation
- Additional measures suggested: history of rapid tranquilisation, advanced statements, discussions recorded within the care plan

5.5 Draft statement 5

People with a mental health problem who experience restraint, rapid tranquillisation or seclusion have an immediate post-incident debrief that addresses physical harm, ongoing risks and the emotional impact of the incident.

Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

- Support for including debrief in the quality standard but concerns around the term immediate
- Concerns that immediate post-incident debriefs are not always possible or helpful
- Suggestion that the debrief should be offered but not be compulsory as not everyone is willing to engage with the debrief directly after a violent episode
- Suggestions about allowing some time (2 hours) for the debrief to take place or offering post incident support if person is not willing to engage

- Suggestion that the debrief should be structured and carried out by staff with relevant training to ensure quality
- Suggestion for the content of the debrief: review of the care plan, precipitants, learning for staff
- Concerns about measurability of the statement
- Service user experience should be added to the measures

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements:

- Principles - reducing restrictive interventions and establishing the most appropriate, and least restrictive method of intervention
- Systemic and psychological interventions such as non-violent resistance (NVR)
- Staff welfare
- Staff training – training needs including preventing violent incidents, assessing risk factors, de-escalation techniques and physical restraint
- Staff attitude and contribution to violence and aggression – staff attitude can contribute to violent episodes; an analysis of incidents reported by service users should be carried out
- Hate related crime – violent episodes cause higher levels of psychological distress including symptoms of depression & anxiety and it takes longer for victims to recover
- Immediate violence – different skills and response are needed as high proportion of violent episodes starts without escalation
- Need for additional resources and facilities– CCTV in GP practices and pharmacies, recording telephone conversations, gym facilities

Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Organisation name	Section	Comments
1	NHS Protect	General	NHS Protect welcomes the inclusion of the reference to the reported physical assaults on NHS staff figures statistics within the 'Quality Standards and Indicators Briefing Paper' document section 2.3. However, please note that the reference is incorrect and should be replaced with the latest 2015/16 figures: http://www.nhsbsa.nhs.uk/Documents/SecurityManagement/Reported_Physical_Assaults_2015-16_Final.pdf
2	Royal College of General Practitioners / Royal College of Paediatrics and Child Health	General	This quality standard covers short-term management of violent and physically threatening behaviour among adults, children and young people with a mental health problem. It applies to settings where mental health, health and social care services are provided. This includes community settings and care received at home. This quality standard will not specifically address violence and aggression among people with primary diagnosis of learning disability because this group has already been covered in learning disabilities: challenging behaviour. However many people with a learning disability access mental health settings where there are no specific learning disability treatment and assessment facilities or they have a concurrent acute mental health illness. The standard should be inclusive to all people in contact with mental health services
3	Royal College of Nursing	General	From a workforce point of view it is encouraging that NICE think the standards will lead to a reduction in injury to staff – but there is nothing concrete on that or any further statement made about staff welfare in handling violent or aggressive behaviour. We suspect that is out of scope of this quality standard but suggest that it would be worth considering a standard around this area in the future.
4	Royal College of Nursing	General	The standards seem appropriate for settings where mental health, health and social care services are provided and support good practice. Staffing levels and appropriate training of staff all affect the ability of individuals and services to manage these situations well.
5	National Association of Psychiatric intensive Care and Low Secure units (NAPICU)	General	Yes the key elements of inclusivity, information sharing, awareness, prevention and early intervention are clearly articulated. Is there adequate mention of appropriate sharing of active management throughout settings when patients transition through inpatient community and back up e.g. advanced directives?
6	National Association of Psychiatric intensive Care and Low Secure units (NAPICU)	General	The mechanisms and descriptions of data collection outlined on page 4 to ensure adequate awareness and opportunity for patients to be involved in standard one are collected at national level in care plan prevalence. Relapse signatures and deterioration are a core part of care planning under CPA (nationally advocated). The data collection method does not have to be local surveys, it can be nationally mandated for collection through NHS Benchmarking and submission to NHSI for quality indicators from providers. Standardised mechanisms of recording V & A history are more variable and are not reported nationally by providers. This Quality standard is advocating standardisation of recording of previous history of V & A to report at local level or nationally. This is not considered an issue and is felt helpful in active management but is not clear as a suggestion.

7	National Association of Psychiatric intensive Care and Low Secure units (NAPICU)	General	None
8	National Association of Psychiatric intensive Care and Low Secure units (NAPICU)	General	If standardised and evidence of proportionately lower incidence of V & A to patient numbers with history of V & A – this would an indicator of proactive management over time – proxy success factors such as use of pro-active management plans in escalation, clear handovers of management techniques in transition of settings, patient involvement. Reduction in V & A incidences reduce staffing injuries and costs, increase positive patient experiences and are linked to reduce length of stays in inpatient care.
9	Cygnet Health Care	Statement 1	This statement does address a priority area for quality improvement and the QI measures within the MH service are achievable. The QI measures are clear and importantly include SU involvement and measuring their experience of the QI measure.
10	Northumberland, Tyne and Wear, NHS Foundation Trust. (NTW)	Statement 1	The high level sources outlined in the paper as stated are already captured, there would be minimal further impact envisaged, the trust has established effective reporting and monitoring systems including levels of aggression and violence.
11	Northumberland, Tyne and Wear, NHS Foundation Trust. (NTW)	Statement 1	The standards would and should be achievable and evaluated at a clinical team level , there is a potential for cost savings if levels of aggression and violence are reduced and impact positively on staff sickness for instance, or additional staffing required to manage increased risk reduces.
12	Northumberland, Tyne and Wear, NHS Foundation Trust. (NTW)	Statement 1	The standards could cover other areas such as primary care, some acute care environments, local authority and voluntary sector.
13	Cygnet Health Care	Statement 1	This statement should apply to people with mental health problems using other services such as primary care and general medicine. An additional QI measure would be assessing staffs awareness of Care plans e.g. therefore supporting the Advance statement when it needs to be followed. Triggers and early warning signs being known outside of mental health services would go some way to reducing violence and aggression and/or getting mental health professionals involved earlier. These should be recorded the same way that they are within mental health services for anyone with a known history and they should be communicated and held with the same regard that advance decisions and statements are. Measurement can be via incident data, patient and staff surveys.
14	Mind	Statement 1	We welcome this statement on involving people with mental health problems who have been violent or aggressive in identifying triggers and early warning signs. This should be in the context of co-produced care planning and previous violence or aggression should not dominate or overshadow a person's care plan unnecessarily. There should be a way for learning from these discussions to be communicated more widely, if for example it speaks to the team or organisation's culture and practices.

15	Northumberland, Tyne and Wear, NHS Foundation Trust. (NTW)	Statement 1	Other methods of eliciting service user views in relation to their experience and involvement in their care are also in place however would require adaptation to clinical recording systems to specifically focus on triggers and whether service users had been involved in identifying such. NTW has developed a range of service user experience tools and also has ready available data relating to violence and aggression to service user level in a dashboard format, in order to improve patient experience and support restraint reduction. Effective clinical supervision should ensure that service users had been involved in identifying triggers within their plans of care.
16	The Association for Family Therapy and Systemic Practice in the UK	Statement 1	Whilst we agree that involving people in identifying triggers and early warning signs is helpful, we do not think this statement goes far enough. The information about triggers and warning signs could helpfully be used to inform care planning and preventive interventions.
17	Northumberland, Tyne and Wear, NHS Foundation Trust. (NTW)	Statement 1	The standard does reflect a key area for quality improvement, although we would also add that antecedents are discussed with the service user, this would be critical in assisting staff and patients understand the function and consequences of the behaviour.
18	Mind	Statements 1 & 2	Re applying these statements to services other than mental health services – this risks being discriminatory by associating violence with users of the service who have mental health problems and not others. It is important to identify people's needs and any risks, but this applies to everyone using a service. It could be part of identifying the need for making adjustments, but should not single out people with mental health problems. Addressing previous violence should be in the context of the person's current circumstances and full range of needs. Any advance statement should be shared with other services in accordance with the individual's wishes.
19	National Association of Psychiatric intensive Care and Low Secure units (NAPICU)	Statements 1 & 2	Could be appropriate for settings such as Prisons where there is a higher likelihood of history of V & A. Measurement could be an initial baseline of graded (in severity) incidences of V & A for previous two years. Implement the standards outlined within this guidance and measure prevalence and serverity – see if there has been a reduction in incidence and / or severity. It would be difficult to apply to a wider range of settings in the community without directly linking mental illness to a generally low prevalence of V & A possibly inadvertently heightening public stigma.
20	Newcastle Gateshead Information Network	Statements 1 & 2	The quality statement does not discuss the communication between organisations. Patients who are violent or aggressive should be flagged with all health and care organisations with whom patient has contact, and included with this the triggers and early warning signs. This both enables other organisations to have in place appropriate support for the patient, including helping patients to identify early signs of deterioration so they can seek help at any early stage.
21	Royal College of General Practitioners / Royal College of Paediatrics and Child Health	Statements 1 & 2	"People in contact with" or who work in "mental health services" Each person should have a personalised care plan which service users are involved in developing which looks at triggers, risk factors, contribution of alcohol or substance misuse and environment

22	Royal College of General Practitioners / Royal College of Paediatrics and Child Health	Statements 1 & 2	Although the level of recorded assault is much lower in other parts of the health services and we (GPs) say we have “zero tolerance” to violence and aggression, many verbal violent and threatening incidents go unrecorded. The standards here should omit “mental” and just be “health services”. More analysis of incidents, which are less than violent but still upsetting for both sides (staff and patients) should be done.
23	Royal College of Psychiatrists	Statements 1 & 2	These quality statements are also applicable in Secure Children’s Homes, Secure Training Centres and Young Offender Institutions, and we therefore see no reason as to why these statements cannot be applicable in non-NHS secure settings for children and young people.
24	Northumberland, Tyne and Wear, NHS Foundation Trust. (NTW)	Statement 2	The standard does reflect a key area for quality improvement
25	Cygnet Health Care	Statement 2	The statement does address a key area for quality improvement, and systems and structures in place support the collation of data for the quality measure. Comments as above regarding involvement in all services and SU involvement. People who use services should be encouraged to make and carry a “de-escalation passport” in the form of an advance statement. Those who use a number of different services and have a history of violence and aggression should expect that staff pass on the information in their “passport” should they find themselves in a situation that they are not able to do so or communicate its contents.
26	Northumberland, Tyne and Wear, NHS Foundation Trust. (NTW)	Statement 2	In order to gain assurance beyond a clinical team level that de-escalation techniques are included in care plans, clinical recording system development would need to be undertaken.
27	Royal College of Psychiatrists	Statement 2	This statement presumes that the planning on handling violent and aggressive episodes is a singular task and does not appear to take account of contextual aspects of violence. In our view Care Plans need to take account of contextual aspects of violence and the use of restrictive interventions should therefore clearly demonstrate the reasons why they were used for different types and levels of violence. We wish to particularly note that violence in secure adolescent settings are very often associated with environmental and staffing issues that are contributory factors in an understanding of violence in institutional settings.
28	Mind	Statement 2	We welcome this statement about involving people with mental health problems who have been violent or aggressive in identifying de-escalation techniques and making advance statements about restrictive interventions. We recommend that people are also involved in developing preventive, coping strategies. In addition, advance statements could address things other than restrictive interventions which, if followed, might reduce the likelihood of violence and aggression. Again, this should be in the context of co-produced care planning and previous violence or aggression should not dominate or overshadow a person’s care plan unnecessarily. Common themes in advance statements may inform organisational improvements.
29	The Association for Family Therapy and Systemic Practice in the UK	Statement 2	The recommendation in statement 2, that people are involved in identifying successful de-escalation techniques, is potentially limited by the experience people have of de-escalation techniques, which in turn might be limited to those currently used in inpatient units, and whilst some of these may be very useful, this potentially limits the learning and progression of de-escalation techniques, particularly those informed by systemic and psychological interventions.

30	Cheshire & Wirral Partnership	Statement 3	It should cover physical obs inline with NEWS National Early Warning Scores
31	Mind	Statement 3	Vital signs monitoring during and after manual restraint is clearly essential (but we don't have expertise on what needs to be included in this). What exactly is covered in this specific standard depends on whether the purpose is to focus on risk to life (which is implicit) or other harms as well. While vital signs are the top priority, it would be important not to deter recording of other physical and psychological harms, including pain.
32	National Association of Psychiatric intensive Care and Low Secure units (NAPICU)	Statement 3	YES - other things should be (attempted to be) monitored post RT, namely blood pressure and oxygen saturation.
33	NHS Improvement	Statement 3	To consider the role of monitoring devices, including pulse oximetry.
34	Northumberland, Tyne and Wear, NHS Foundation Trust. (NTW)	Statement 3	The standard does reflect a key area for quality improvement, NTW would suggest baseline physical observations are available in order to provide a crucial comparison following restraint
35	Northumberland, Tyne and Wear, NHS Foundation Trust. (NTW)	Statement 3	Additional observations may need be carried out depending on service users physical health or pre-existing health issues. This should be articulated within the plan of care.
36	Northumberland, Tyne and Wear, NHS Foundation Trust. (NTW)	Statement 3	In order to gain assurance beyond a clinical team level that de-escalation techniques are included in care plans, clinical recording system development would need to be undertaken.
37	Cheshire & Wirral Partnership	Statement 3	The recording of evidence for physical health monitoring during restraint would be difficult due to safety of equipment needed, resulting in staff physically observing for signs of deterioration.
38	Cheshire & Wirral Partnership	Statement 3	What does the word 'check' mean when used for monitoring physical observations? Is there a minimum standard i.e. visually if the threat of violence/harm is to others great to undertake a physical check involving medical devices?
39	Royal College of Psychiatrists	Statement 3	Monitoring of vital signs can be helped by the use of pulse oximetry. In addition, given the concerns to physical health in different types of restrictive interventions (particularly prone vs supine restraints); we would recommend a system able to monitor physical health in different types of restrictive intervention, rather than combining the modalities under one umbrella (namely 'manual restrain') as the guide currently suggests.

40	Cygnet Health Care	Statement 3	The statement does address the need to evidence Physical Health monitoring during and post restraint, though the guidance needs to be more specific regarding minimum Physical Health standards of measures that should be implemented for all restraints. When these minimum standard measures are agreed the service would have systems and structures in place to collect the data required. Although there is a recognised risk of death from obstructing airways and positional asphyxia during manual restraint; measuring physical observations at this time can be very difficult because of the patient struggling. The observation levels will not be within normal limits because of the physical exertion therefore will not give staff useful data about the patient's condition. The focus should be more on ending manual restraint as quickly as possible and the statement should say that physical observations during manual restraint should be done where there is a prolonged restraint (guidance on times would need to be given to identify what a prolonged restraint is). Staff should be encouraged to use other methods of assessing the patient's physical wellbeing during all manual restraints such as level of consciousness, communication, pallor, behaviour, etc. For all other cases the focus needs to be on physical observations being done after manual restraint for ongoing assessment of physical wellbeing. For Statements 3 and 4 ,the QI improvement measure "Harm to the person occurred needs to clarify physical harm (if that is the aim of the measure) as inevitably the trauma of the event and potential for traumatisation is psychological harm", and that it is harm caused to the person during the restraint.
41	NHS Improvement	Statements 3 & 4	We welcome standard 3 and 4. Quality statement: QS Group will be aware, restrictive interventions also include seclusion. QS Group to consider referencing this in addition to manual restraint and rapid tranquilisation. In the alert we note risk of death after restrictive interventions may also affect people without a previous history of mental illness e.g. patients experiencing delirium, head injury etc. Because of this, should your Quality Statement also include these vulnerable groups and all organisations providing NHS-funded care where restrictive interventions or manual restraint are (or might be used), including healthcare provided in prisons, acute, ambulance services, etc.? Rationale: NICE may wish to note and reference our Patient Safety Alert: The importance of checking vital signs during and after restrictive interventions/manual restraint https://www.england.nhs.uk/patientsafety/2015/12/03/psa-vital-signs-restrictive-interventions/ Quality Measure: Structure & Process The group to consider including responsibility for reliably recording and documenting vital signs to be specified in local procedures, mandatory training and routine audit to be undertaken as part of evidence of local arrangements.
42	Royal College of General Practitioners / Royal College of Paediatrics and Child Health	Statements 3 & 4	Significant variation in use of face down restraint between Trusts. Consider each episode of face down restraint as a near miss and undertake a root cause analysis. Staff undertaking restraint must be appropriately trained to carry out the technique and assess potential alternatives and in the monitoring of a person's physical health. Staff undertaking restraint must be trained in intermediate CPR and have access and be able to use an automatic defibrillator. Staff training and access to appropriate drugs and equipment is the same for all types off restraint including chemical restraint.

43	Royal College of Psychiatrists	Statement 4	'Rapid tranquillisation' is probably the wrong terminology to use. The reality is that intramuscular medication does not act particularly rapidly and patients are not 'tranquillised'. The most that is achievable through the use of psychopharmacological treatment is to reduce a patient's agitation.
44	Cygnet Health Care	Statement 4	The definition of RT is different to the one in the MHA CoP as it only considers IM medication. It is however in line with NG10. This difference causes confusion for clinicians. Is there any way that the quality standard can give further guidance on the correct definition and also give guidance on oral meds as RT and the monitoring required for this? The MH service benchmark RT use against the CoP definition which will impact on level of RT use, and potentially be methodologically flawed if comparing with other services that maybe benchmarking against the NICE definition. An additional quality improvement measure would be to check if the service user has a history of RT use, that it has been discussed with the service user as part of their care plan and advanced statement (Numerator V Denominator) and that it addresses risks such as other medical conditions, side effects, BNF limits .SU survey could be an additional QI measure.
45	Northumberland, Tyne and Wear, NHS Foundation Trust. (NTW)	Statement 4	The standard does reflect a key area for quality improvement.
46	Northumberland, Tyne and Wear, NHS Foundation Trust. (NTW)	Statement 4	In order to gain assurance beyond a clinical team level that service users are monitored appropriately following rapid tranquilisation would require clinical recording and incident system development.
47	Cheshire & Wirral Partnership	Statement 4	Monitoring post RT – is there a minimum standard of observation if the patient is in seclusion for harm to others?
48	Cheshire & Wirral Partnership	Statement 4	It would be difficult to cover GP's without Psychiatric services input
49	Mind	Statement 4	Physical health monitoring during and following rapid tranquillisation is also essential. It is important not to ignore the psychological impact of rapid tranquillisation but this may be better addressed through debrief.
50	Royal College of Psychiatrists	Statement 4	The definition of 'vital signs' might need further explanation. If vital signs are considered to mean: pulse, blood pressure and respiratory rate, then the reality is that if a patient requires intramuscular medication to manage severe violence or aggression, it would be unlikely that intrusive observations like pulse or blood pressure would be carried out. This is because the level of proximity required to do these observations may actually increase the risk of another incident. Monitoring of 'vital signs' would therefore be limited to external observations of respiratory rate, hydration, and level of consciousness.
51	Northumberland, Tyne and Wear, NHS Foundation Trust. (NTW)	Statement 5	The standard does reflect a key area for quality improvement.
52	Northumberland, Tyne and Wear, NHS Foundation Trust. (NTW)	Statement 5	The phrasing in the standard relates to' immediate' the phrasing should reflect that this is not always possible or indeed desirable within this time frame.

53	Northumberland, Tyne and Wear, NHS Foundation Trust. (NTW)	Statement 5	NTW would suggest something like 'when the person is ready' and 'there are suitably trained/experienced staff available to undertake post incident support' in the first instance then a more detailed 'debrief' should this be appropriate.
54	Northumberland, Tyne and Wear, NHS Foundation Trust. (NTW)	Statement 5	Poorly applied debrief has potential to be damaging to both the service user and staff. NTW has developed a structured process, underpinned by training for staff undertaking post incident support and debrief.
55	Cheshire & Wirral Partnership	Statement 5	The word 'immediate' will not always be achievable due to ongoing risks present. Can the word be removed and indicate that a post incident debrief must take place?
56	Cheshire & Wirral Partnership	Statement 5	Under 'what the statement means for different people' – 'seclusion (taking the person to a room away from everyone else) are used to help calm someone down quickly when all other methods haven't worked', this does not meet the MHA CoP definition.
57	Cheshire & Wirral Partnership	Statement 5	It would be difficult to cover GP's without Psychiatric services input
58	Cygnet Health Care	Statement 5	Rather than stating "have an immediate post-incident debrief" can the statement consider saying "should be offered an immediate post-incident debrief". This is because not everyone who has been involved in an incident wants to or benefits from talking about it immediately. There needs to be an element of choice in engaging in the debrief. This can be further expanded to state that where patients do not want to or cannot engage in a debrief then post incident support should be offered. This support is to be tailored to the needs of each patient. NG26 recommends offering support to all rather than a debrief so a minor adjustment to the statement would make it in line with that guideline.
59	Elysium Healthcare	Statement 5	This statement may be hard to measure because having worked in this field for a number of years my experience has led me to believe that patients who immediately have a post-incident debrief may still be in a state of crisis, may feel quite upset or angry about what has just happened/occurred and may require more time after said incident to calm prior to any form of debrief or post-incident debrief occurring. My personal opinion would be to offer an immediate post incident debrief and allow from time of crisis up to 2 hours post incident. This may in turn allow the patient to calm and to express their thoughts/feelings in a more appropriate way. This time line post restraint, rapid tranquillisation or seclusion may allow time for the patient to have returned to their normal baseline behaviour. We may also consider that immediate post-incident debrief may challenge staff's safety and may allow for re-escalation of trauma of event of both staff and patient. Having a de-brief to soon after the event may not aid the achievement of required information and process as it may feel too soon for the patient/staff and the patient/staff may not wish to comment or disclose relevant information while still in a potential heightened state of arousal. Staff may not also be available immediately after a crisis or intervention to offer a structured or worthwhile post-incident debrief due to ward environmental or situational aspects which in turn may be linked to said previous crisis or incident so rather than spending time to conduct the post-incident debrief appropriately may skip over the relevant or required issues. Terry Heenan, Management of Violence and Aggression Director. Elysium Healthcare

60	Mind	Statement 5	We strongly welcome inclusion of debrief, as this is the way that people who have been restrained can give their perspective and the indications are that it is still relatively uncommon (in NSUN's survey carried out in 2016, 81 per cent of people had no follow-up communication or debrief). However we have serious concerns at how the standard is phrased: "people who have experienced restraint … have an immediate post-incident de-brief…" The standard (and to some extent the guideline) conflates the care and support a person is likely to need after an incident (which will need to be immediate), de-brief and support of staff and witnesses, and exploring with the person their perspective on what happened, what led up to it and how things might have happened differently. For the latter, it really needs to be a proactive offer and done in the right way at the right time. This is reflected in the guideline (up to a point) but does not come across here, where "immediate" could be taken too literally. We recommend more precise wording and providing supporting information on good practice. We welcome that service user experience is integral to the measure.
61	Royal College of General Practitioners / Royal College of Paediatrics and Child Health	Statement 5	Debrief should also include a review of the person's care plan, analysis of precipitants and learning for staff. Recurrent episodes of violence should be addressed as near misses and reviewed appropriately. People should be cared for in an appropriate environment and if required escalated to Psychiatric Intensive Care (PICU) for example.
62	Royal College of Psychiatrists	Statement 5	Immediate post-incident debriefs can on occasions be not only counter-productive but also impossible. In secure settings for young people, there is a proportion of patients who engage in very frequent violent incidents and 'immediate post-incident debriefs' would need to be balanced against the ability of a young person to be able to take on board the whole gamut of processes this quality statement wishes to address. We think therefore that 'post-incident debriefs' need to occur but they need to be tailored to the ability of the young person to be able to take on board such work for it to be effective and debriefs need to take account of need and responsivity issues.
63	Royal College of General Practitioners / Royal College of Paediatrics and Child Health	Additional areas	Related to above: CCTV on wards and in pharmacies and GP reception should also be routine.
64	Hampshire Constabulary	Additional areas	I feel there is a gap in the statements. There is no reference to establishing the most appropriate, and least restrictive method of intervention. With the recent Carlile review around Police intervention, it is vital that we have a joined up response across agencies, acknowledging the limits of what each agency can provide. Police will always rely on pain compliance techniques, and NHS staff need to understand the circumstances where this will be appropriate.
65	Mind	Additional areas	The statements are all important areas for improvement, but we would have also liked to have seen a statement addressing prevention or reduction of restrictive interventions (across a setting or organisation, not only through secondary prevention with individuals). Despite guidance and work to reduce restrictive interventions, the overall indications are that the use of physical restraint remains high - http://www.mind.org.uk/news-campaigns/news/use-of-physical-restraint-still-widespread/#.WKbWVk2mnIU

66	Royal College of General Practitioners / Royal College of Paediatrics and Child Health	Additional areas	Under environment and prevention it is generally agreed and observed that having gym facilities, as well as opportunities for leisure activities and updated facilities and maintenance (for example no blocked sinks and toilets) help prevent triggers.
67	Leicestershire Partnership NHS Trust	Additional areas	I have taken the opportunity to look at the Violence & Aggression Quality Standards & overall I think it is a strong document the only comment I would make is that I think there could be some added value if more visibility, consideration & recognition was given to Hate related crime/incidents when considering violence & aggression via Incident & Cause reporting processes across inpatient/outpatient settings which reflect the national & local Hate Crime reporting strands in order to better support & empower staff/patients who have been affected by for e.g 5 monitored strands race, religion, disability, sexual orientation, transgender status, through violence or verbal abuse which has the capacity to escalate. Our work is ultimately focused on short/med term increases in reporting & longer term decreases in incidents which have a hate element attached to them through reporting, support, education & awareness campaigns with the intention of helping to reduce violence & aggression long term. Since July 17 we at Leicestershire Partnership NHS Trust have added Hate to our Incident & Cause reporting & it has unearthed a not insignificant number of incidents which have a hate element, race being the most prominent, we have implemented a system of follow up & support for staff & patients affected at no extra resource cost. We can now run reports & pick up on themes/trends across our inpatient & outpatient settings which have a hate element providing us with valuable insight into where a problems exist & offer practical supportive responses around reporting & wellbeing support for staff & patients affected. The hate incident/cause data feeds directly into our Missing Persons Violence Risk Reduction Group. We are also in the process of rolling out Hate Crime posters with information on how to report across our wards & public facing areas. These posters (Stamp It Out) contain powerful images & simple messages aligning to the 5 reporting strands. We also display a Hate Crime & Healthcare Partnership commitment plaque which has been signed by local organisational NHS senior leaders across the partnership-Leicestershire Partnership NHS Trust, University Hospitals of Leicester, East Midlands & Ambulance Service & the 3 local CCG's. We also have an E-Learning module for staff which is health service specific which has been rolled out across the local partnership-it is available to all staff which currently stands at around 20,000 providing consistency & continuity. Hate related crime & incidents cause higher levels of psychological distress including symptoms of depression & anxiety, it is well documented that it takes longer for victims of hate motivated crime & incidents to recover than other forms of non-targeted victimisation. Rather than send data & an overview of our system, support pathways & learning module-can you first let me know if this is an area that interests you & if so I can prepare some information to send.

68	NHS Protect	Additional areas	We support that there should be an appropriate system in place at a local level to benchmark progress against this quality statement. At a national level, NHS Protect already has a system (Security Incident Reporting System (SIRS)) which records incidents of physical assault, including indicators of escalation, such as accompanying non-physical abuse, theft and criminal damage. This would be a good metric for this quality statement and we would be very happy to assist further if required. This data suggests that in the mental health sector only 23.2% physical assaults include accompanying non-physical abuse, theft or criminal damage. It is reasonable to assume that a significant proportion of incidents are immediate violence with very little perceived escalation. This requires a whole different skill set to manage high risk situations which is currently omitted and we recommend should be covered in this quality standard. A full breakdown is available here: http://www.nhsbsa.nhs.uk/Documents/SecurityManagement/SIRS_RPA_-_A_Five_Year_Analysis_of_Physical_Assaults_against_NHS_Staff_in_England_-_V2.3.pdf
69	Royal College of General Practitioners / Royal College of Paediatrics and Child Health	Additional areas	MIND and the RCN highlight that the attitudes of many staff contribute significantly to violence and aggression. So there should be an analysis and patient reporting of incidents too.
70	The Association for Family Therapy and Systemic Practice in the UK	Additional areas	It is helpful that NICE has developed both a clinical guideline and a quality standard for the short-term management of violence and aggression. However the focus on the short time frame in these, seems to be excluding potentially helpful systemic and psychological interventions for violence and aggression.

71	The Association for Family Therapy and Systemic Practice in the UK	Additional areas	A number of AFT members provide testimony to the effectiveness of non-violent resistance (NVR) and the evidence base for this intervention is developing. Whilst we appreciate this may be more suited to a clinical guideline, it is another opportunity for us to bring this to the attention of NICE. Please also see quote below: “NVR is relevant to the short-term management of violence and aggression… …NVR aims specifically for the immediate cessation of violence, and actually achieves this very quickly, and also its focus on de-escalation not as an add-on, but an integral part of the therapeutic approach. “ NVR UK 15.2.2017; Below are some references for outcome studies. Empirical Evidence of NVR, Four RCT (Random Control Trials) studies have so far provided evidence of the effectiveness of NVR in several countries: 1. Weinblatt and Omer (2008) delivered a five-session individual NVR training (completed by 10 sessions of telephone support) to 21 families of children aged four to 17 years with acute behavioural problems and compared it with a waiting list control group of 20 families. Parents who received NVR training showed reductions in parental helplessness and escalatory behaviours and improvements in perceived social support. Furthermore, parents reported significantly less externalizing problem behaviour in their children. The effectiveness of the treatment was independent of the age of the children: The authors found similar results in families with adolescents (12–17 years) and in families with children under 12 years of age. Moreover, attrition in this study was very low: Only one family ended the treatment prematurely. 2. Ollefs, von Schlippe, Omer, and Kriz (2009) compared an NVR treatment of 6–10 individual sessions in 59 families with a Group Teen Triple P treatment in 21 families and a waiting list control group (nine families). NVR and Group Teen Triple P showed comparable improvements relative to the control group in terms of increased parental presence and decreased feelings of helplessness and depression in parents. A significant decrease in externalizing problem behaviour was found only in the NVR group. Follow-up one month after treatment in both studies showed that the results remained stable. 3. Levavi (2010) focused on escalation patterns. She compared 26 treatment families (NVR trained) with a waiting list group of 20 families. Fathers and mothers reported on their own and on their spouse’s escalation patterns. Three components of escalation were measured: parental submissiveness, power struggles and negative emotions. There were improvements in all three, especially from the fathers’ point of view. There was also a significant reduction in parental helplessness. 4. Van Holen, Vanderfaeillie, & Vanschoonlandt (2013) did the most recent RCT in Belgium with foster parents. They collected data from 25 foster families and found significant reductions in externalizing, internalizing, and total problem behaviour in the foster children and in parenting stress and significant improvements in externalizing, internalizing, and total problem behaviour in, respectively, 72, 44, and 80% of the cases. References for NVR evidence base: Gleniusz, B. (2014). Examining the evidence for the non-violent resistance approach as an effective treatment for adolescents with conduct disorder. Context 132, pp 42-44. Jonkman, C.S, Van der Soet, K, Van Gink, N, Godard, N, Van der Stegen, B. & Lindauer, R.J.L. : The effects of nonviolent resistance in a child and adolescent psychiatric ward setting. Unpublished manuscript. Lavi-Levavi, I. (2010). Improvement in systemic intra- familial variables by "Non- Violent Resistance" treatment

			for parents of children and adolescents with behavioral problems, PhD dissertation, Tel- Aviv University, Tel Aviv. Newman, M, Fagan, C & Webb, R (2013). The efficacy of non-violent resistance groups in treating aggressive and controlling behaviour in children and young people: a preliminary analysis of pilot NVR groups in Kent. Child and Adolescent Mental Health 19/2, pp 138-141 Ollefs, B., Von Schlippe, A., Omer, H., and Kriz, J. (2009) Adolescents showing externalising problem behaviour. Effects of parent coaching (German). Familiendynamik, 3: 256-265. Van Holen, F., Vanderfaellie, J., & Omer, H. (2016). Adaptation and evaluation of a nonviolent resistance intervention for foster parents: a progress report. Journal of Marital and Family Therapy 42(2): 256-271. Weinblatt, U. & Omer, H. (2008). Non-violent resistance: A treatment for parents of children with acute behavior problems. Journal of Marital and Family Therapy 34, pp.75-92. Tools used by in CAMHS and Children Services who deliver NVR to measure outcome: IAPT measures The Goals (pre and post), SDQ and the SUDS -parental unit of distress (post and pre SDQ forms), Achenbach child behavioural change measure, Feedback from for facilitator and referrers, Question for non-starters, Feedback from for non-attenders, Conflict behaviour questionnaire

72	Royal College of General Practitioners / Royal College of Paediatrics and Child Health	Additional areas	Much aggression and violence is expressed in phone conversations – both from mental health staff particularly as well as patients who are desperate for something and feel frustrated. There should be routine recording of telephone conversations. This is easy to measure.
73	NHS Protect	Additional areas	We are aware that staff training and competencies are not usually within the remit of quality standards. We would however emphasise that this document should include a training standard (or at least reference one) for all staff to be skilled on how to prevent incidents from occurring by carrying out proper risk assessed clinical observations and assessments of the reasons for someone's violent or aggressive behaviour, which should be incorporated within their care plan. Without this being in place, this element of this statement will not be met, see our clinically led guidance at: http://www.nhsprotect.nhs.uk/reducingdistress/
74	NHS Protect	Additional areas	We are aware that staff training and competencies are not usually within the remit of your quality standards however, we would emphasise that this document should include a training standard (or at least reference one) for all staff to be skilled on how to carry out de-escalation techniques (including dynamic risk assessments) on how to deal with violent behaviour. Without this being in place, this statement will not be met, see our clinically led guidance at: http://www.nhsprotect.nhs.uk/reducingdistress/ http://www.nhsbsa.nhs.uk/Documents/SecurityManagement/Standards_for_providers_2016-2017_Security_management.pdf
75	Royal College of General Practitioners / Royal College of Paediatrics and Child Health	Additional areas	All staff should receive training in the dynamic assessment of risk factors and how to minimise them. Episodes of violence should be considered significant events and a significant event analysis undertaken. Thought should be given to victims of violence whether staff or other patients.
76	Royal College of Nursing	Additional areas	Recognising that Prison healthcare has only recently come under the responsibility of the NHS, it would be helpful and valuable if there was wider recognition and engagement with Health Education England to address training needs of this workforce.
77	Royal College of Nursing	Additional areas	Whilst we recognise that this is out of the scope of this standard, some guidance and direction to commissioners on their responsibilities in commissioning services to ensure adequate staffing levels and appropriate training are included in tender specifications would be helpful.

Registered stakeholders who submitted comments at consultation

- Cheshire & Wirral Partnership
- Cygnet Health Care
- Elysium Healthcare

- Hampshire Constabulary
- Leicestershire Partnership NHS Trust
- Mind
- National Association of Psychiatric intensive Care and Low Secure units (NAPICU)
- Newcastle Gateshead Information Network
- NHS Improvement
- NHS Protect
- Northumberland, Tyne and Wear, NHS Foundation Trust (NTW)
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Paediatrics and Child Health
- Royal College of Psychiatrists
- The Association for Family Therapy and Systemic Practice in the UK