Quality Standards Advisory Committee 3

Violence and aggression – prioritisation meeting

Multimorbidity - prioritisation meeting

Minutes of the meeting held on 16 November 2016 at the NICE offices in Manchester

Attendees	**Standing Quality Standards Advisory Committee (QSAC) members** Dr Hugh McIntyre (Chair), Jim Stephenson, Geeta Kumar, Darryl Thompson, David Pugh, Julia Thompson, Gillian Parker, Malcolm Fisk, Ann Nevinson, Deryn Bishop, Karen Ritchie, Ben Anderson, Rhian Last, Ulrike Harrower, Lauren Aylott, Keith Lowe. **Specialist committee members** **Violence and aggression** - Anthony Bleetman (left early), Joy Duxbury, Elena Garralda, Nick Nalladorai, Belinda Salt, Faisil Sethi. **Multimorbidity** - Nina Barnett (arrived late), Sam Barnett –Cormack, Carolyn Chew- Graham, Andrew Clegg. **NICE staff** Nick Baillie (NB), Craig Grime (CG), Anna Wasielewska (AW) [agenda items 1-9], Nicola Greenway (NG) [agenda items 10-15], Helen Vahramian (HV). **NICE Observers** Ian Mather
Apologies	**Standing Quality Standards Advisory Committee (QSAC) members** Eve Scott, Madhavan Krishnaswamy, Susannah Solaiman, Martin Siddorn.

MORNING SESSION		
Agenda item	**Discussions and decisions**	**Actions**
1. Welcome, introductions and plan for the day (private session)	The Chair welcomed the attendees and the Quality Standards Advisory Committee (QSAC) members introduced themselves. The Chair informed the committee of the apologies and reviewed the agenda for the day.	
2. Welcome and code of conduct for members of the public attending the meeting (public session)	The Chair welcomed the public observers and reminded them of the code of conduct that they were required to follow. It was stressed that they were not able to contribute to the meeting and were there to observe only. They were also reminded that the committee is independent and advisory therefore the discussions and decisions made on the day may change following final validation by NICE's guidance executive.	
3. Committee business (public session)	**Declarations of interest** The Chair asked standing QSAC members to declare any interests that were either in addition to their previously submitted declaration or specific to the topic(s) under consideration at the meeting today. The Chair asked the specialist committee members to declare all interests. The following interests were declared: **Standing committee members** Lauren Aylott • February - September 2016, worked as an Assistant Psychologist for Tees, Esk and Wear Valleys NHS Foundation Trust as part of the Force Reduction Project team. The aim of the force was to reduce the use of restrictive interventions across the trust (e.g. use of restraint, rapid tranquilisation and seclusion) through the use of behaviour support, safewards and debrief as well as other strategies, highlighted in NICE NG10. **Specialist committee members** Elena Garralda • Personal financial non-specific interest: Has shareholdings in pharmaceutical companies, but the manufacturers do not produce drugs relevant to the committee topic.	

	Anthony Bleetman • Serves as an independent expert providing advice on the medical risks of physical intervention training packages in the mental and acute health services. Has no vested interest in any provider. **Minutes from the last meeting** The committee reviewed the minutes of the last meeting held on 21 September 2016 and confirmed them as an accurate record.	
4. QSAC updates	The dates of meetings up to March 2017 to be circulated. Dates of meetings beyond that will be confirmed over the coming weeks.	
TOPIC PRIORITISATION – VIOLENCE AND AGGRESSION		
5 and 5.1 Topic overview and summary of engagement responses	CG and AW presented the topic overview and a summary of responses received during engagement on the topic.	
5.2 Prioritisation of quality improvement areas	The Chair and AW led a discussion in which areas for quality improvement were prioritised. The QSAC considered the draft areas as outlined in the briefing paper prepared by the NICE team. The outcome of discussions is detailed below. 1. Discussion of the individual statements was preceded by some discussion about the scope of the QS.	1. The NICE team was asked to clarify the scope of the quality standard in regards to locations that are not typically considered to be care settings, including activities of health care professionals in custodial settings for adults and young people and in accident and emergency

		departments.
	2. As an observation relating to all the prioritised areas, the committee asked for the quality standard to reflect the importance of organisational factors in triggering or reducing risks of violence and aggression. These included physical environment, management style and practices; organisation culture, staff competence. People with mental health problems and the prioritised quality improvement areas were all susceptible to the influence of organisational factors.	2. NICE team to consider including this when drafting the quality standard.

Suggested quality improvement area	Prioritised (yes/no)	Rationale for prioritisation decision	If prioritised, which specific areas to be included?
1. Anticipating violence and aggression			
<u>Risk assessment</u>			
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	NO	The guideline was largely focussed on the service user whereas stakeholders focussed more on the role of organisational factors in raising or reducing risk. Apart from stakeholder and specialist member comments pointing to variable practice, there was limited evidence on the use and efficacy of risk assessment tools.	
<u>Care planning</u>		The available tools were largely generic but some members expressed the view that their efficacy lay	
Encourage service users to recognise their own triggers and early warning signs of violence and aggression and other vulnerabilities, and to	YES	in the fact that a structured approach was better than an unstructured one in identifying risks and triggers and was better than clinical judgment alone. Balanced against this was the already very heavy risk assessment burden across service areas and it would not be helpful to add a further blanket	1. Care planning to be prioritized with provision for identification and discussion with the service user of potential triggers and how these could be managed when they occur. 2. The NICE team to also consider the applicability of 1.2.7 to care planning in home and community settings.

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.		recommendation. Some members were not persuaded that risk assessment could predict short term episodes in advance. A more nuanced approach through targeted care planning could be helpful for the small minority of service users who had a known or recognised potential for violent or aggressive episodes. This would also allow for elements of risk management and a collaborative approach that included the service user.	
2. De-escalation <u>Communicating</u> One staff member to take the primary role in communicating, assessing the situation for safety, seeking clarification with the service user and negotiating to resolve the situation in a non-confrontational manner. <u>Designated area or room</u> To reduce emotional arousal or agitation and support the service user to become calm.	YES	As a general point, the committee was keen to prioritise de-escalation as an improvement area. There is a consensus that good de-escalation practices reduce or avoid the need for restrictive ones. De-escalation practices are widely understood although there are complexities in their use. They lie at one end of a spectrum of measures for calming violent episodes. Although they are typically used prior to restrictive intervention, they can be deployed at any point on the spectrum. There is a lack of national data, but evidence from stakeholders indicates a tendency for staff in some care settings to move onto the spectrum of restrictive interventions prematurely. The committee sounded a note of warning that de-escalation communication techniques were more that simple talking cures. They encompassed a	1. The quality statement will need to take account of relevant initiatives and work streams within the NHS and Department of Health. 2. The NICE team was asked to follow up a contact at the Department of Health.

		range of methods and models which demanded specific competencies for which there was specific training. Allowing for context, a potential measure of de-escalation could be developed from complaint and adverse incident data. A setting which has a significant number of complaints and incidents is likely to be one that favours restrictive techniques over de-escalation.	
3. **Prevention interventions** <u>Medication</u> Processes for prescription of p.r.n. medication as part of a strategy to de-escalate or prevent situations that may lead to violence and aggression. <u>Psychological support</u> Ensuring 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	NO NO	SCMs highlighted that the intention of the guideline was to make a clear distinction between the preventive use of p.r.n medication and restrictive use of rapid tranquillisation. However, it is not intrinsically preventive as its efficacy depends on the way it is used. P.r.n. medication is often requested by patients who feel anxious or recognise early signs of increasing agitation. Withholding prn medication has the potential to be misused - as a sanction or a way of staff being in the position of power/being in control. Its preventive or restrictive role depends on how it is used and the circumstances of the individual patient. The committee considered that the efficacy of preventive aims could be reflected more generally within other quality statements and the requested preamble on the importance of organisational context. The same advice applies to psychological support.	1. NICE team to consider within overall drafting of the quality standard.

difficulties.			
4. **Using restrictive interventions** <u>Physical health and monitoring of vital signs</u> Ensuring that restrictive interventions are performed safely, with regard for physical health and with continued monitoring of vital signs. <u>Immediate post-incident debrief and formal review</u> 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.	YES YES	Within the guideline, restrictive intervention is used as an umbrella term, but it also refers specifically to rapid tranquillisation and to manual restraint. Both are associated with morbidity. There are especially high risk factors connected with the use of manual restraint. Monitoring of vital signs is expected during pharmacological interventions but is not always possible during manual restraint. The committee considered that safety is of paramount importance. This should be approached through ensuring that these techniques are used only as a last resort, after other available options have been considered. Immediate post-incident debriefing will ensure that this is built into the process. The committee also pointed out that manual restraint is a team technique that should never be attempted by an individual carer and is therefore inappropriate as a community care option. Given these issues, there was a consensus on the need for two separate quality statements on: 1. The appropriate and correct use of manual restraint.	1. The NICE team is asked to develop two statements, in consultation with specialist members. 2. It is suggested that an effective measure on the use of restraint can be derived from 1.4.55 and 14.4.56 of the guideline

		2. Immediate post-incident debriefing with a root cause analysis to ensure that other approaches were considered and exhausted first and that manual restraint was the last resort.	
5. **Working with the police** <u>Health and social care provider organisations should work with the police</u> To develop policies for joint working and locally agreed operating protocols <u>Managing violence and aggression</u> Community mental health teams should not use manual restraint in community settings.	NO NO	Members appreciated the need for local health-focussed working protocols or memoranda of understanding between care organisations and police forces. However with impending new police legislation, the police rules of engagement with mental health incidents were changing. It might no longer be possible to assume police intervention in community incidents. This will be subsumed within the quality statement on manual restraint.	No action

Additional areas suggested	Committee rationale	Area progressed (Y/N)
Management of Acute Behavioural Disturbance (ABD) within ED Stakeholders suggested that Management of Acute Behavioural Disturbance (ABD) within ED should be prioritised	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.	**NO**
Mental health in prisons	These are areas address general and much wider issues of health and violence in	**NO**

Stakeholders highlighted increasing violence, self-harm and access to resources within the prison population.	prisons which are outside the scope of this QS. Separate guidance and quality standards are in development on the physical and mental wellbeing of people in prisons.	
Monitoring compliance Stakeholders suggested that monitoring compliance with the guideline in CAMHS as an area for quality improvement.	Quality standards recommend measures for monitoring compliance with specific statements. Monitoring compliance with/implementation of the guideline is outside the remit of QS.	**NO**
Staff training Stakeholders made a range of suggestions around identifying effective staff training and different types of training needed.	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.	**NO** NICE team were asked to consider whether a cross reference to Department of Health initiatives is appropriate.

6. Resource impact	The committee was initially asked to consider resource impact whilst prioritising the areas for quality improvement. No significant resource impact had been highlighted at the guideline development stage. The members were advised that resource impact question would be asked at consultation and stakeholders comments considered during the next meeting.	
6.1 Overarching outcomes	The NICE team listed overarching outcomes that could be improved by implementing a quality standard on violence and aggression. The committee suggested: 1. "Use of antipsychotic drugs" should be deleted 2. Current outcomes do not sufficiently communicate the importance of the organisation's role in reducing restrictive interventions. 3. Robust approach to de-escalation should be included to reduce the use of physical and pharmacological interventions. It was agreed that the committee would contribute suggestions as the quality standard was developed.	
6.2 Equality and	The NICE team explained that equality and diversity considerations should inform the development of the	NICE team were asked to

diversity	quality standard, and asked the committee to consider any relevant issues. It was agreed that the committee would contribute suggestions as the quality standard was developed.	clarify the scope of the quality standard in regard to people with dementia and in custodial environments where people with particular vulnerability are located.
7. QSAC specialist committee members (part 1 – open session)	AW asked the QSAC to consider the constituency of specialist committee members on the group and whether any additional specialist members were required.	The technical team to: 1. Endeavour to strengthen the stakeholder representation among police and parent/youth organisations 2.Contact the following organisations to join the stakeholder list: Royal College of Psychiatrists Association of Chief Police Officers Association of Directors of Social Services College of Policing Young Minds Branches of Public Health England responsible for health and justice
8. Next steps and timescales (part 1 – open session)	The NICE team outlined what will happen following the meeting and key dates for the violence and aggression quality standard.	
9. Any other	The following items of AOB were raised:	

business (part 1 – open session)	• Statement on rapid tranquilisation was brought up; it had been discussed earlier but it wasn't explicitly agreed as an area that should be progressed; at this point the committee asked NICE team to include statement on rapid tranquilisation; **Date of post-consultation meeting for Violence and Aggression: 22 March 2017**	NICE team to include statement on rapid tranquilisation
AFTERNOON SESSION **TOPIC PRIORITISATION – MULTIMORBIDITY**		
10. Welcome and code of conduct for members of the public attending the meeting (public session)	The Chair welcomed the public observers and reminded them of the code of conduct that they were required to follow. It was stressed that they were not able to contribute to the meeting but were there to observe only. They were also reminded that the committee is independent and advisory therefore the discussions and decisions made today may change following final validation by NICE's guidance executive.	
11. Committee business (public session)	**Declarations of interest** The Chair asked standing QSAC members to declare any interests that were either in addition to their previously submitted declaration or specific to the topic(s) under consideration at the meeting today. The Chair asked the specialist committee members to declare all interests. The following interests were declared: **Standing committee members** Gillian Parker • Has received funding from NIHR to investigate admission avoidance. Deryn Bishop • Has worked on a toolkit for workforce development in integrated care. <u>Specialist committee members</u> Nina Barnett • Taught on a joint venture medicines optimisation training programme on 16 sept 2016 which included ABPI as sponsors. Will be receiving payment for teaching, hospitality and overnight accommodation the night before the teaching session. Sam Barnett-Cormack	

	• Has made public statements on social media about shortcomings in care for people with multiple long-term conditions. However, he is not a "public figure" and is generally quite prepared to change his mind on things, publicly, so he does not consider himself restricted by these statements in any way (and would have to look them up to know what they were). Andrew Clegg • Led the development and validation of an electronic frailty index (eFI) that uses routine primary care electronic health record data to identify and grade frailty. The eFI has been implemented into UK primary care electronic health record (EHR) systems (SystmOne and EMISWeb) under the terms of a license agreement stating that it is freely available to end users at no additional charge. Has no financial interest in the implementation or use of the eFI. Carolyn Chew-Graham • Received research funding from NIHR to conduct research, as part of multi-disciplinary teams, in which the focus in a number of studies is multimorbidity.	
12 and 12.1 Topic overview and summary of engagement responses	CG and NG presented the topic overview and a summary of responses received during engagement on the topic. The committee were pleased to note the number of stakeholders that commented on the topic engagement who represented a wide range of healthcare professionals.	
12.2 Prioritisation of quality improvement areas	The Chair and NG led a discussion in which areas for quality improvement were prioritised. The QSAC considered the draft areas as outlined in the briefing paper prepared by the NICE team. The outcome of discussions is detailed below. The committee discussed the role of self-management in improving outcomes, using for example, health literacy, coaching and digital technologies. Where appropriate this should be reflected in the individual quality statements. However, the committee were mindful that an emphasis on self-management has the potential to widen inequality gaps for some service users as well as improve outcomes for others. The Chair asked the specialist committee members to clarify the difference between multimorbidity and frailty and how they may overlap. The committee were advised that frailty usually, but not exclusively, occurs with old age, onset of physical problems, weak muscles, difficulty in routine daily activities. People with frailty are a sub-group of those with multimorbidity, comprising about 15-20%, who are more likely to	NICE team to reflect this where appropriate, within the draft quality standard

	suffer adverse outcomes.	

Suggested quality improvement area	Prioritised (yes/no)	Rationale for prioritisation decision	If prioritised, which specific areas to be included?
1. **Identification** <u>Use of an appropriate tool</u> To routinely identify people with multimorbidity in primary care who may benefit from a tailored approach to care.	YES	The committee were advised that there are significant differences in approaches nationally to identify people with multimorbidity, which create inequalities. People with multimorbidity can include several subpopulations including those with frailty, those taking 15 or more medications and those who meet the definition of multimorbidity and have mental health problems, drug and/or alcohol dependency or learning disability who would benefit from a different approach to health care. There are differences across the country regarding which subgroups are included in identification. Advice from committee members is that whilst individual GPs are generally aware of individual people in the vulnerable subgroups, GP practices are not aware of them in any systematic way that leads to action. Thus these groups tend to receive uncoordinated multiple medication reviews with no one responsible for their overall health status. The intention of this quality statement is to identify people at risk in a systematic way as this first step to	NICE team to develop a statement on the proactive identification of people with multimorbidity who may benefit from an approach to care that takes account of multimorbidity.

		providing a tailored approach to care and offers the potential to drive significant improvement. However, identification should not be entirely top down. It must enable people to self-identify if they are struggling to cope and need extra support.	
2. **Frailty** Identification of people with frailty in primary and secondary care So that evidence based interventions can be delivered to improve outcomes.	YES	The guideline recommends effective tools to assess frailty. The committee agreed that assessment of frailty was not performed well in either primary or secondary care and in particular at discharge from hospital. However not all the settings are supported by the recommendations which only provide effective tools in primary and secondary outpatient services. The committee agreed a key area for quality improvement was effective sharing of information between primary and secondary care.	NICE team to develop a quality statement on the appropriate method to be used to assess frailty in primary care and secondary outpatient care.
3. **Assessment** Establishing the effects of health problems and treatment on day-to-day activities Establishing patient goals, values and priorities	YES	The adoption of a quality statement in this area would provide an important patient-centred and collaborative approach to health care. Establishing a patient's principal goals, values and priorities has the potential to be an important driver for bringing about improved quality of life and outcomes and where appropriate, in reducing the treatment burden. However, a collaborative approach must also be	NICE team to develop a quality statement on establishing patient's goals, values and priorities.

		sensitive to issues of capacity and consequently the need for advocacy that will be a factor with some patients.	
4. **Reviewing medicines and other treatments** <u>Medicines and other treatments should be reviewed regularly</u>. Specifically to look at how they work together. To ensure medicines are working effectively and are the best option which in turn increases adherence to medication and quality of life.	YES	A significant problem for people with multimorbidity is the disjointedness of their treatment and having to attend for several reviews for different conditions. It is important to move away from the tick box approach to medication review in order to identify any accumulated medication burden and adverse drug interactions. The statement must also be clear that this is a review of all treatments, not just medication and that it should be holistic and collaborative.	NICE team to draft a statement on reviewing medicines and other treatments that reviews the interactions between treatments and their effects on the individual and is done collaboratively. Technical terms like de-prescribing and polypharmacy should be avoided in order to communicate the intended person-centred approach.
5. **Management plan** <u>Developing a management plan</u> A single individualised management plan that sets out personal goals, identifies care	Pending	The committee acknowledged the potential utility of a management plan that promoted coordination of care, and identified some features that they would expect to see in one as stated in 1.6.17. Some of these features listed had the potential to overlap with existing quality standards for example shared decision making which is included in the patient experience quality standard. The committee also recognised that the presence of a management plan did not guarantee the quality of the plan or its	NICE team to develop a statement on specific features of the management plan.

and support needs to manage physical and mental health and wellbeing and includes preferences for care. <u>Reviewing the management plan</u> Providing an opportunity to discuss what is working, where changes to the plan need to be made and changes in personal priorities. consistently documented and available to all relevant healthcare professionals		implementation. There was a strong case for specifying coordination and communication of patient goals and priorities across a range of services but the committee were not fully persuaded that it would be practicable and measurable until stakeholders had been consulted. Concerns were raised about who would be expected to provide this plan and have lead responsibility. The committee therefore agreed to identify specific issues for the focus of the statement, those being assigning knowledge and the sharing of information. The committee discussed that some subgroups of people with multimorbidity, including frail elderly people, would already have care plans. The committee wanted to avoid multiple management plans.	

Additional areas suggested	**Committee rationale**	**Area progressed (Y/N)**
Self-management Self-management through structured education and peer support	NG advised the committee that the guideline had considered the role of self-management programmes but concluded there was insufficient evidence on which to base a recommendation. The quality standard therefore could not include a statement on self-management as there were no recommendations to support it.	**NO**
Carer assessment Health and support needs assessed and documented as their own physical and	Covered by the Care Act 2014	**NO**

mental health are at risk of getting worse when providing care for someone with multimorbidity.		
Training For healthcare professionals in recognising the prognostic indicators for approaching end of life in multimorbidity.	Outside the remit of quality standards	**NO**
Integrated personalised commissioning To achieve success in joining up health and social care provision around the needs of an individual at a local level.	Outside the remit of quality standards	**NO**
Comprehensive geriatric assessment Comprehensive geriatric assessment for all frail aged over 75 years in secondary care	Covered by Transition between inpatient hospital settings and community or care home settings for adults with social care needs due to be published 2016	**NO** Include reference to this quality standard and the relevant statement.
Shared decision making Through the provision of clear, accurate, evidence-based, easy to use information	Covered by Patient Experience in Adult NHS Settings Quality Standard (QS15).	**NO** Include QS15 as a related quality standard and consider referencing the relevant statements
Surgical care People with multimorbidities are more likely to suffer complications and death following surgery.	Not covered by the guideline	**NO**
Access to services People with co-occurring conditions are often unable to access the care they need	Not covered by the guideline	**NO**

Outcomes Including quality of life	NG advised the committee the suggested outcomes would be considered as part of the overarching outcomes the quality standard was hoping to achieve.	**NO** NICE team to review if appropriate to include in the overarching outcomes

13. Resource impact	At this stage, a minority of committee members considered that there would be a small additional resource impact through more time needed for primary care consultations. The majority of members considered the statements would be cost neutral.	
13.1 Overarching outcomes	The NICE team explained that the quality standard would describe overarching outcomes that could be improved by implementing a quality standard on multimorbidity. It was agreed that the committee would contribute suggestions as the quality standard was developed. The committee highlighted that the Adult Social Care Outcomes Framework should be referenced for this quality standard as it contains several indicators relevant to people with multimorbidity and the outcomes expected from them receiving an approach to care that takes account of multimorbidity.	**Reference social care outcomes**
13.2 Equality and diversity	The NICE team explained that equality and diversity considerations should inform the development of the quality standard, and asked the committee to consider any relevant issues. It was agreed that the committee would contribute suggestions as the quality standard was developed. The committee highlighted the following groups • travellers, ex-military personnel and vulnerable people in secure and custodial settings which would be relevant for consideration for all quality standards • capacity and advocacy for people with dementia and learning disabilities • younger people with multimorbidity as it is often viewed as a condition that only affects older people • ethnic minorities as specific conditions can make the presence of multimorbidity more likely	**NICE team to highlight capacity and advocacy for people with dementia and learning disabilities and younger people with multimorbidity in the quality standard.** **NICE team to confirm the position of travellers, ex-military personnel and vulnerable people in secure and custodial settings.**
14. QSAC specialist committee members (part 1 – open session)	NG asked the QSAC to consider the constituency of specialist committee members on the group and whether any additional specialist members were required. **Specialist members**: It was agreed the appropriate specialist committee members had been appointed.	

	The committee asked the NICE team to identify further stakeholders from social care and also service providers in the fields of drug and alcohol dependency and youth agencies to invite to comment at consultation.	
15. Any other business (part 1 – open session)	The following items of AOB were raised: 1. The NICE team to consider circulating the list of stakeholders for each topic with the papers for the meeting **Date of post-consultation meeting for Multimorbidity : 22 March 2017** **Date of next QSAC3 meeting: Friday 20 January 2017** **HIV testing – prioritisation** **Rehabilitation after critical illness - prioritisation**	