NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETING

Meeting Date: 25 February 2015

Title and Author of Paper:

Violence Prevention Strategy

Gail Kay – Directorate Manager – PMVA steering group chair
Dr Keith Reid – Lead Consultant – PMVA steering group chair

Paper for Debate, Decision or Information: Information

Information – The strategy document has been subject to a formal consultation process and amended, as appropriate, in response to feedback

Key Points to Note:

The strategy outlines the vision for Northumberland, Tyne and Wear NHS Foundation Trust over the next five years 2014 -2019.

Key messages are as follows;

NTW does not accept the occurrence of incidents of aggression and violence, and the restrictive interventions required to manage such incidents, as inevitable in our mental health and learning disability services.

As a healthcare provider NTW aspires to eradicate aggression and violence, self directed and towards others, from our services by implementing an organisational strategy that enhances our understanding of the causes and allows us to progress the interventions necessary to promote a service that is safe for our patients, staff and the wider community working together with stakeholders to achieve this goal.

The implementation of the violence prevention strategy aims to encourage all clinical services to review practices and indeed philosophies of care in order to maximise the safety of everyone.

The strategy promotes collaborative working to ensure our service users are cared for in environments that are safe and focus on evidence based therapeutic intervention and recovery by teams committed to a culture of incident reporting, meaningful debrief and clinical risk review to inform organisational learning.

The strategy is in line with contemporary developments at a national level and embraces the principles outlined in the Department of Health Positive and Proactive Care initiative. (Department of Health, 2014)

The NTW strategy outlines leadership, assurance, accountability and monitoring arrangements to ensure transparency and demonstrate an organisational learning culture aimed at improving care.

The violence prevention strategy focuses on the delivery of effective health services and the principles are embedded in a ***CARE*** framework which incorporates the values defined by the Chief Nursing Officers "6c's" (Commissioning Board Chief Nursing Officer and DH Chief Nursing Advisor, 2012).

> ***C* – Communication (and commitment to high standards): Recognising and incorporating compassion in our engagement, competence in delivery, communication in all situations, and courage in application and review. These are our core values and central to everything we do;**
>
> ***A* – Accessibility: Recognising that our role is to meet our service user needs, we will be accessible, respectful and approachable with a primary focus on working together to provide the highest standards of care and treatment.**
>
> ***R* – Responsibility: Recognising that the prevention of aggression and violence is everyone's business, collectively and individually we are accountable for the safety and security of all. The personal and professional accountability and integrity involved is enhanced by high standards of competence and professional courage;**
>
> ***E* – Empathy: The use of compassion and care to recognise the need to understand each individual's life experience in order to progress meaningful and sustainable recovery plans in collaboration with their family/carers.**

The strategy is supported by a structured implementation plan and will be subject to a process of evaluation.

Outcome required:

Support to implement the strategy and evaluate impact.

Northumberland, Tyne and Wear NHS
NHS Foundation Trust

Violence Prevention Strategy

Applies to:	ALL directly employed and agency staff ALL Contractors when working for NTW
Lead Officer	Executive Director of Nursing and Operations
Author(s)	**Gail Kay** Directorate Manager, Central Community, Planned Care Group **Dr. Keith Reid** Lead Consultant, Adult Forensic Services
Date ratified	February 2015
Ratified by	Trust Board
Date of Issue	March 2015
Date of Review	March 2018
Version	V01

Review and Amendment Log	**Version**	**Type of change**	**Date**	**Description of change**
	V01	NEW	Mar 15	NEW Document

Violence Prevention Strategy

EXECUTIVE SUMMARY

FORWARD

Northumberland Tyne and Wear NHS Foundation Trust (the Trust/NTW) does not accept the occurrence of incidents of aggression and violence, and the restrictive interventions required to manage such incidents, as inevitable in our mental health and learning disability services.

We aspire to eradicate aggression and violence, self directed and towards others, from our services by implementing an organisational strategy that enhances our understanding of the causes and allows us to progress the interventions necessary to promote a service that is safe for our patients, staff and the wider community working together with stakeholders to achieve this goal.

*"***Understanding the context of violence is vital in designing interventions. All societies experience violence, but its context - the circumstances in which it occurs, its nature and society's attitude towards it - varies greatly from one setting to another. Wherever prevention programmes are planned, the context of violence must be understood in order to tailor the intervention to the targeted population."** (World Health Organisation, 2002)

NTW accepts that our staff members have a legal, ethical and professional obligation to prevent harm to themselves and others and acknowledge that interventions to prevent a greater occurring harm are sometimes necessary.

The NTW violence prevention strategy focuses on primary prevention and safe and therapeutic secondary and tertiary intervention which is carried out in a culture of care and recovery.

Our overall aim is to minimise the use of all restrictive interventions and promote collaborative working to ensure our service users are cared for in environments that are safe and focus on evidence based therapeutic intervention and recovery by teams committed to a culture of incident reporting, meaningful debrief and clinical risk review to inform organisational learning.

Despite major progress in the last decade, some clinical settings have a continued over-reliance on the use of seclusion, restraint and rapid tranquillisation. Action to address the underlying cultural dimensions via an organisational strategy is key to achieving our service improvement objectives

The implementation of the violence prevention strategy aims to encourage all clinical services to review practices and indeed philosophies of care in order to maximise the safety of everyone. NTW recognises that the cost of inaction is excessive in both human and financial terms and ongoing review is essential to inform further improvement.

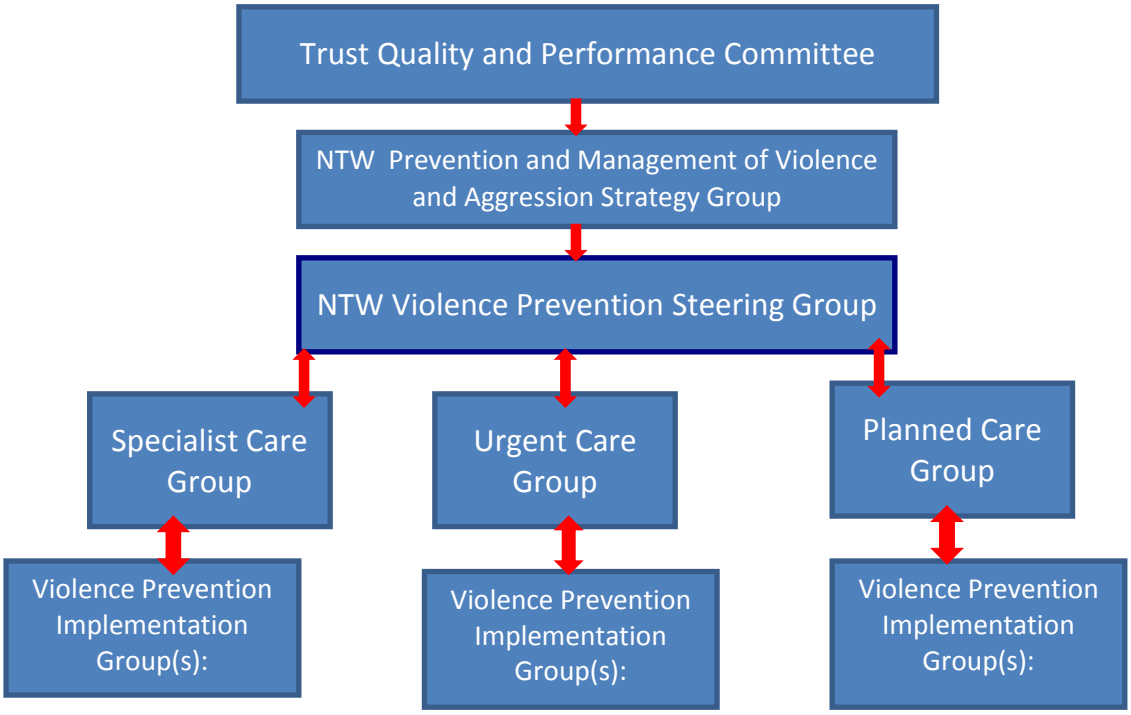
The strategy is in line with contemporary developments at a national level and embraces the principles outlined in the Department of Health Positive and Proactive Care initiative. (Department of Health, 2014)

The NTW strategy outlines leadership, assurance, accountability and monitoring arrangements to ensure transparency and demonstrate an organisational learning culture aimed at improving care. The violence prevention strategy focuses on the delivery of effective health services and the principles are embedded in our ***CARE***

framework which incorporates the values defined by the Chief Nursing Officers “6c’s” (Commissioning Board Chief Nursing Officer and DH Chief Nursing Advisor, 2012).

This strategy does not exist in isolation: its intention is to interact with and support the Trust’s strategic direction, workforce, governance, involvement and inclusion and service strategies, it aims to be focused, action led and dynamic to allow for continuous improvement, providing a framework through a number of strategic aims and key objectives which will be taken forward within each Group. Diagram 1 outlines the governance structure in place to ensure that the operational delivery of the strategy is monitored within the groups and progress is reported to the Board of Directors via Trust Quality and Performance Committee the responsible Executive Lead (O'Hare, 2013). (Diagram 1)

Diagram 1- Governance Structure



1 Introduction

1.1 Northumberland, Tyne and Wear NHS Foundation Trust (the Trust/NTW) is a large Mental Health, Learning Disability and Neuro-Rehabilitation Trust providing services to a population of approximately 1.4 million, with some of the country's highest levels of deprivation in a mix of urban and large rural areas. The Trust employs over 6000 staff of which over 4000 nurses make up the largest professional group.

1.2 The Trust Vision is:

"To improve the wellbeing of everyone we serve through delivering services that match the best in the world".

1.3 The Trust aims to deliver clinical excellence, provide high quality care and treatment within safe services which meet nationally and internationally accepted best practice.

1.4 In June 2013, MIND produced a report titled, Mental Health Crisis in Care: Physical Restraint in Crisis - A Report on Physical Restraint in Hospital Settings in England (MIND, 2013).

1.5 This report presented data on the use of physical restraint for the year 2011 to 2012. Fifty-four mental health trusts were approached via a Freedom of Information request. Approximately half of the trusts approached, provided figures for prone restraint. (NTW) reported the highest number of prone restraints (923).

1.6 In August 2014 a further freedom of information request identified an increase in the number of reported incidents of self directed harm in mental health services in England. Twenty one of fifty trusts approached provided responses and NTW was again highlighted as reporting the highest number of incidents and a year on year increase of 2,008 to 3,746. Further work is occurring in relation to the management of self harm and the need to have in place suicide prevention measures as part of the public health agenda. The relevant clinical guidance and NTW strategies and policies are being reviewed to support the violence reduction strategy.

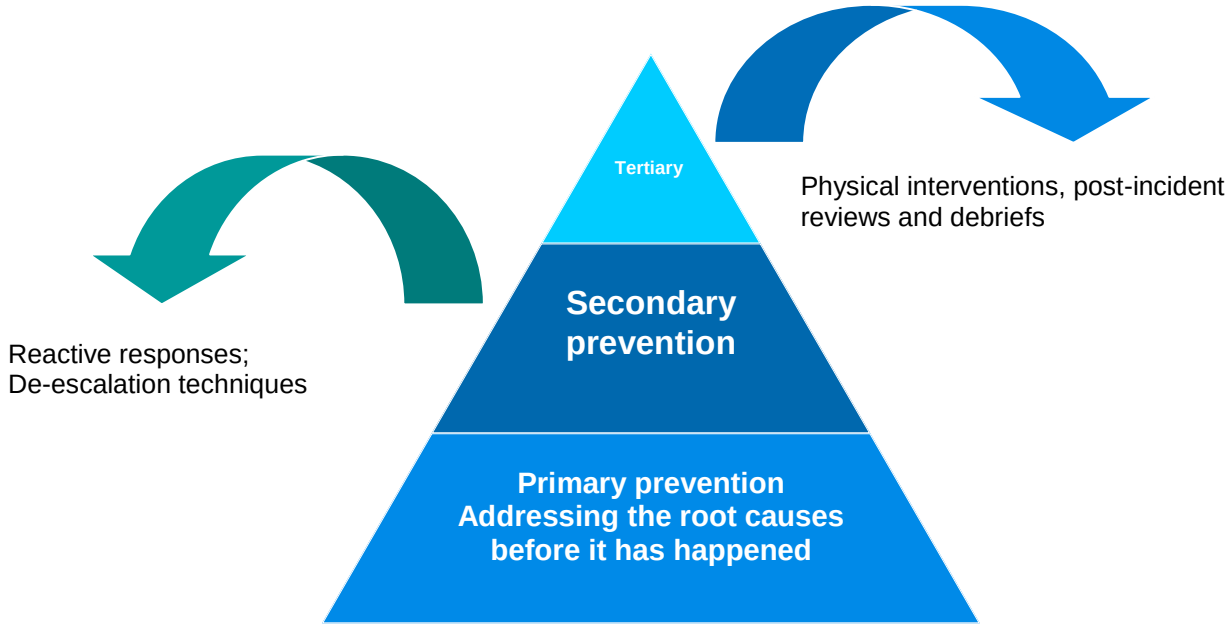
1.7 NTW provides a number of local and national specialist services across a diverse range of clinical areas. The Freedom of Information findings are not reflective of the complexity of the services we provide and as such the comparisons with other trusts are not informative in terms of analysis. They do however provide a focus for the objectives set out in this strategy.

1.8 The strategic aim is to reduce and ultimately eradicate violence from our services by developing an understanding of the causes of such incidents. We recognise the need to address incidents of aggression and violence to others and self directed harm by our service users. Restrictive interventions are utilised to manage such risks; understanding the cause of the behaviour, progressing interventions to reduce the risk of occurrence, will impact on the frequency of restraint, seclusion and tranquillisation and subsequently improve the safety of our service users, staff and others.

2 Change and Reform

2.1 A number of potential models to prevent workplace violence exist. The public health model advocated by the World Health Organisation (Krug et al (Cited in), 2002) represents prevention as having three interlinked dimensions: primary, secondary and tertiary. (Diagram 2).

- **Diagram 2 – Public Health Model**



2.2 Each dimension is important, but the emphasis is on primary prevention. A structured approach to effective culture change requires primary prevention to be introduced in order to address the underlying triggers.

2.3 The ability of staff to intervene via de-escalation (secondary prevention) or manage incidents via, for example, physical intervention (tertiary) also needs to be considered.

2.4 Tertiary prevention also recognises the need for thorough post-incident review procedures in order to ensure lessons are learned from incidents arising and that action is taken to prevent the risk of re occurrence.

2.5 Primary prevention requires action at every level of the service including;

- the service user
- the individual worker
- the staff team
- broader organisation

2.6 Making prevention uppermost in the minds of all parties via the organisational strategy will help promote cultures which recognise the types of behaviour which

give rise to violence and progress effective interventions to reduce risk. Implementation of primary prevention strategies requires attention to longstanding and widespread cultural problems within the services in relation to the nature of staff relationships with service users, the roles of practitioners and their wider skills. The effect of, for example, physical environments and staffing levels must also be considered (Fisher, 2003) (Colton, 2004). Ongoing education must aim to facilitate a shift in the emphasis from secondary and tertiary prevention (and the historical emphasis on crisis management) to a focus on prevention through organisational learning. Thoughtful, planned and strategic change, which is subject to rigorous local evaluation, in terms of its impact on both service users and staff, is therefore our priority.

3.1 For primary prevention to be effective, it is essential to understand the cause rather than simply address some underlying symptom. This requires proactive intervention from the outset by engaging with the individual to identify triggers and jointly agree supportive interventions. Many incidents of violence arise from the individual feeling frightened, frustrated, vulnerable, disregarded or ignored. While the causes of violent outbursts are not always easy to ascertain the effects of the social and physical environment have been identified in the literature as potential causes.

3.2 By considering the situation in conjunction with the intervention, the service user's history and current presentation, clinical teams can start to anticipate the likelihood of violence and construct plans to reduce the risk. When a violent act is initiated by a service user, the root cause of it cannot be ignored. Paterson and colleagues (2007) suggested that these may include: failures by services to meet users' needs; failures by services to meet the wide and specific health needs of people with mental illness; the nature of relationships between staff and service users; failures by services to meet the needs of staff; the unrecognised but inevitable emotional impact of previous violence on staff; the unrecognised but inevitable impact of previous traumatic experiences on service users.

4 Secondary Prevention

4.1 Secondary prevention relies on the need for effective observation, early intervention, engagement and positive communication. This level of prevention relies upon conflict resolution and de-escalation skills. Conflict may occur due to a number of factors (e.g. internal triggers, external triggers, and a mixture of both) and staff should be sensitive to the potential of these in order to minimise the risk of situations escalating.

4.2 Internal triggers can include: symptoms (e.g. paranoid ideas may impact on the service user's interpretation of events. Care plans should reflect the impact of such symptoms); Emotional states (e.g. fear or frustration can lead to poor communication and confrontation.) Multidisciplinary team members must make every effort to positively engage with service users and understand when their emotional state has altered.

4.3 External triggers can include loss of liberty, excessive noise, poor staff attitudes, being ignored, etc.

4.4 Every effort must be made establish preventative interventions by carrying out thorough risk assessment based upon a good understanding of a person's history. It often helps to ask people what external triggers have led to incidents in the past and

discuss strategies to minimise these in the future through collaborative care planning. The impact of the service users physical and mental health must be considered, this includes their ability to understand and make sense of what is happening to them within this context. Additionally, post-incident assessment is essential to establish the cause and to agree future care plans and coping strategies.

4.5 De-escalation is always the preferred intervention when confronted with potential violence. This should only be superseded when delaying the use of other interventions would result in the risk of physical harm. In some areas it may be necessary to intervene promptly to avoid a situation escalating, knowledge of the service user and associated risk factors will help inform necessary and proportionate staff responses.

5 Tertiary prevention

5.1 The practice of Control and Restraint (C+R) was initiated in prison services but its extension into some healthcare settings was undertaken without adequate consideration of service cultures and indeed service purpose. Despite major progress in the last decade, evidence continues to indicate that some settings have a continued over-reliance on the use of physical restraint and other restrictive practices and fail to take action to address underlying cultural dimensions. The concept of 'zero tolerance' can be misplaced in mental health and learning disability services duke to the complexity of the physical and psychological needs of the service users.

5.2 Service users enter mental health services in acute distress often frightened and angry, sometimes acutely fearful of admission based on previous experiences of restraint (Bonner G, 2002). What they find on admission is not necessarily an environment that offers temporary sanctuary alongside skilled individualised evidence based treatment. Instead as Bloom observed their experience may be of 'rigid rules, humiliating procedures, conflicting and often disempowering methods, and inconsistent, confusing and judgmental explanatory systems' (Bloom, 1997).

5.3 The service users prior experience of interpersonal and societal violence may have led the person to display what is characterised as mental illness, or indeed criminal behaviour, in the first place (Smith, 1995) (Hiday, 1997). Physical restraint interventions are never 'treatments' but in order to be ethically and professionally defensible they must take place in the context of a therapeutic relationship.

5.4 There are primary reasons for the deployment of physical restraint techniques:

- prevention of harm to self or others
- prevention of escape from treatment (detained patients)
- administration of essential treatment (in accordance with legal / ethical decision making procedures)
- prevention of a criminal act, for example, damage to property

5.5 There is however growing evidence that service users question the motivation and thus, the legitimacy of staff actions when physical restraint is used no matter what method is employed.

5.6 Any form of restraint, physical, mechanical, environmental or chemical constitutes restrictive and intrusive treatment and all services have a duty to seek to minimise its

use. It is acknowledged that certain circumstances and presenting risk may merit the need for physical restraint to be utilised in order to prevent a greater harm from occurring. It is vital, therefore, that where any restraint procedures are used, deploying staff are fully aware of the risks involved. These risks and the associated precautions must be addressed in training syllabi which places them within a legal, ethical and professional context. All forms of restraint are potentially dangerous; staff deploying restraint are also at risk of physical injury and potential psychological harm.

5.7 Tertiary prevention recognises the need for thorough post-incident review procedures in order to ensure lessons are learned from incidents arising and that action is taken to prevent the risk of re occurrence and minimise associated harm.

6 Our Vision

6.1 The strategy outlines the vision for Northumberland, Tyne and Wear NHS Foundation Trust over the next five years 2014 -2019. If we are to achieve this we will need to ensure we have a competent and capable workforce with a primary focus on the provision of safe and therapeutic care.

6.2 In order to progress this strategy recommendations from relevant documents were reviewed as outlined in the bibliography. Following the review of the literature the Trust is adapting the safer services model (Miller, 2003) to implement and monitor the organisational components of an integrated violence prevention strategy. This also incorporates the values defined by the Chief Nursing Officers "6c's" (2013) which are increasingly considered as a value base for NHS multi-professionals.

- The safer services structure identifies the key elements of organisational development required to prevent aggression and violence in services

- The application of the strategy is underpinned by our **CARE** principles:

C **– Communication (and commitment to high standards):**

Recognising and incorporating compassion in our engagement, competence in delivery, communication in all situations, and courage in application and review. These are our core values and central to everything we do;

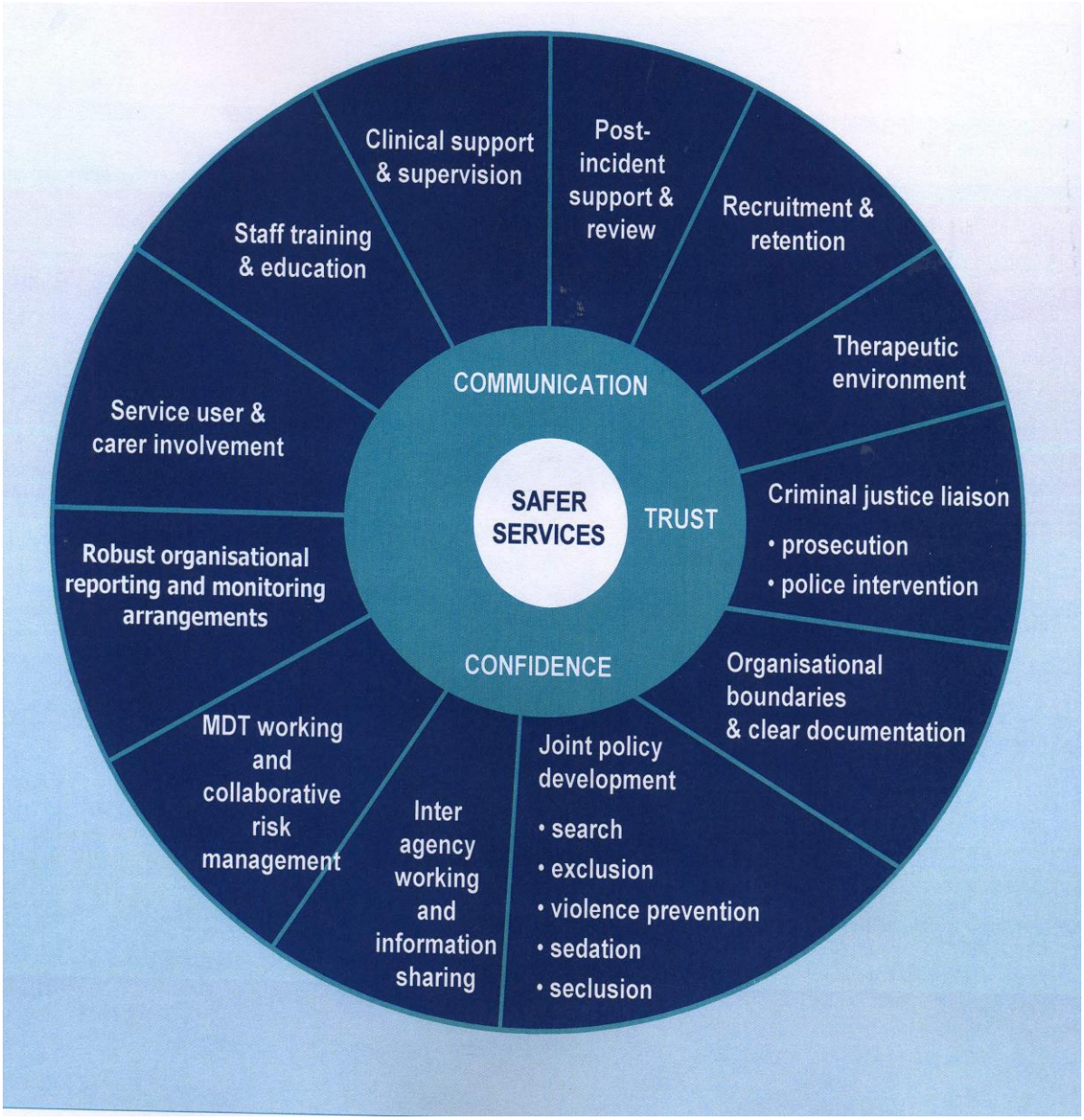
A **– Accessibility: Recognising that our role is to meet our service user needs, we will be accessible, respectful and approachable with a primary focus on working together to provide the highest standards of care and treatment.**

R **– Responsibility: Recognising that the prevention of aggression and violence is everyone's business, collectively and individually we are accountable for the safety and security of all. The personal and professional accountability and integrity involved is enhanced by high standards of competence and professional courage;**

E **– Empathy: The use of compassion and care to recognise the need to understand each individual's life experience in order to progress meaningful and sustainable recovery plans in collaboration with their family/carers.**

6.3 Our strategy is multifaceted as outlined in diagram 3:

Diagram 3 (Updated safer services)



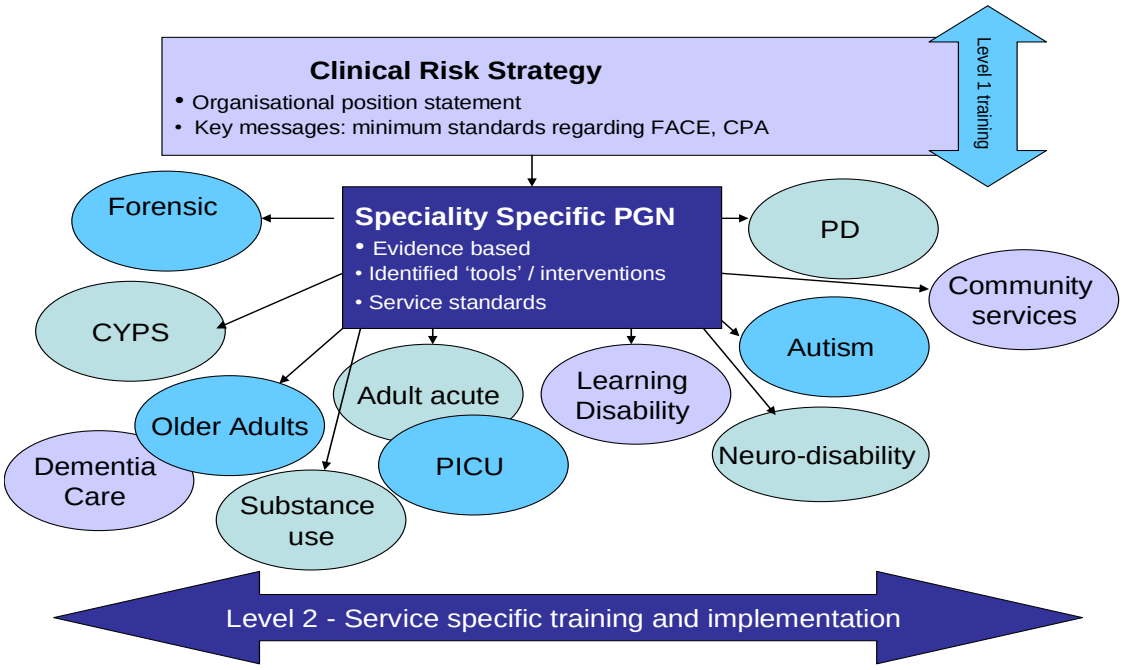
6.4 In order to implement the strategy objective, that is, eradicate violence from our services by developing an understanding of the causes of incidents, we need to progress the following;

7 Develop staff training and education

7.1 The provision of evidence based training that integrates policy into practice in line with bespoke service need is recognised. The need to underpin all training with the values of a caring profession is outlined in a recent review of training. The recommendations describe the need for violence prevention training to be available at induction, mandatory for all disciplines; this has been accepted by the organisation. An implementation plan will be progressed to ensure that the training provided is regularly reviewed and that the bespoke needs of clinical services are

addressed. The proposed structure for all clinical risk training is outlined in diagram 4 below.

Diagram 4: Clinical Risk Training Infrastructure



8 Clinical support and supervision

8.1 Supervision is key to setting and maintaining clinical standards. The transfer of skills into practice requires mentoring and monitoring structures that add value to the staff experience and positively impact on service user care. The development of multidisciplinary supervision structures linked to service objectives will be progressed as part of ongoing workforce planning.

8.2 It is imperative to establish clinical leadership within the service environment to ensure that values and clinical skills training is modelled in terms of identifying risk, developing care plans and supporting individuals during incidents by, for example, ensuring that clinically qualified staff are accountable for leadership in restraint situations , and that each monthly clinical and professional supervision involves an analysis of each restraint episode that they have led to ensure appropriate reflection and learning.

9 Post incident support and review

9.1 The public health model outlines the need for post incident review to inform prevention planning. The post incident process needs to recognise two elements;

1. **Organisational learning** – To reduce the risk of re-occurrence and inform service improvements;

2. **Individual / team support** – To support individuals (staff and others) who have experienced actual or potential harm as a result of the incident. Post incident review with the service user is required to fully

understand the reason for the incident, the impact of the incident and to progress future interventions via a collaborative process

9.2 An approved model for post incident support and review will be developed by the violence reduction strategy group; this will be implemented and evaluated.

10 Recruitment and retention

10.1 The recruitment and formation of teams with the relevant values, skills and knowledge has been observed as an enabler to the prevention of aggression and violence in services. Teams who have trust and confidence in each other and communicate effectively produce better outcomes. The need for MDT ownership of the locality based prevention strategies will be promoted via the strategy launch.

10.2 Organisational arrangements to recruit staff teams with the appropriate values are in place, this includes systems to minimise the use of temporary staff. Workforce planning will take account of the skills and knowledge required to develop expertise in services and provide opportunities to further develop staff.

11 Therapeutic Environments

11.1 The physical care environments are being reviewed as part of the overall service modernisation programme. This includes new build in- patient facilities, environmental upgrading and a review of locality based team bases in the community. It is recognised that the therapeutic environment is influenced by other factors, for example, levels of acuity and staffing levels/ The wider therapeutic engagement aspects are addressed via training, supervision, policy and other facets of the safer services model. The Estates plan outlines the ongoing programme of work that is in progress to ensure the physical environments meet with the identified best practice standards, and the development and operation of low aggression/low impact care settings.

12 Criminal Justice and Police Liaison

12.1 Statutory legislation outlines an individuals' right to pursue action via the criminal justice route (including staff, patients and the public). National memorandums of understanding have been developed with the NHS and criminal justice services to ensure that appropriate action occurs to manage this process. The Trust has in place liaison arrangements to take forward the required actions. The joint working arrangements and supporting procedures will be reviewed by the violence prevention strategy group in order to implement and monitor a consistent approach. It should be noted that morally and ethically all clinical violence is not necessarily a criminal act, but a manifestation of clinical or psychiatric distress.

13 Organisational boundaries and clear documentation

13.1 The concept of zero tolerance can be misplaced in mental health and learning disability services. The complex reasons for violence and aggression need to be understood and interventions applied that are in line with for example, the intent to harm and impact of incidents. However, the recognition that aggression and violence is not acceptable within NTW has to be communicated and posters and information leaflets are in place to ensure everyone using, visiting or working in our services is

aware of the boundaries of acceptable behaviour. The posters and leaflets will be reviewed by the violence prevention strategy group and re-launched as part of the strategy in consultation with the Trust communications lead.

14 Joint policy development

14.1 The prevention of aggression and violence is not a stand alone issue. There are various clinical risk and patient safety policies that link to this and an integrated approach to ensure consistency is outlined in the training review. An overarching clinical risk strategy is being progressed to join the key elements of clinical risk management together and ensure a total organisational approach occurs. This includes the review of systems to monitor and response to changing levels of acuity and clinical activity. This will be monitored by the violence prevention strategy group.

15 Interagency working and information sharing

15.1 The need to work effectively with other agencies is paramount to effective care delivery in the modern NHS. Gaps in information sharing have been identified as themes in a number of public inquiries in the UK. The need for robust joint working and 'common sense' information sharing is a key enabler in the service users' recovery journey. The need to ensure risk information is shared is essential and arrangements for effective communication need to be in place across services. Due to the complex service infrastructures in NTW operational groups will be required to review the arrangements in place, identify gaps and prepare action plans outlining the remedial action required within agreed timescales.

16 MDT working and collaborative risk management

- **'Recognising that the prevention of aggression and violence is everyone's business, collectively and individually we are accountable for the safety and security of all'**

16.1 As outlined in the violence prevention principles the implementation plans for the strategy need to be implemented at an operational group level and owned by teams. Each group will progress a prevention plan and will have in place monitoring systems to ensure this is disseminated to teams. Updates will be provided via the violence prevention strategy group, any emerging themes that inhibit progress will be addressed. The principles of primary prevention will underpin the locality work plans and service specific evidence based interventions to aid prevention planning will be implemented, for example, positive behavioural support planning, dementia care mapping, Wellness Recovery Action Planning (WRAP).

17 Robust organisational reporting and monitoring arrangements

17.1 The need to collate and review service delivery information will be a core role of the operational group governance structures. Each group will monitor incidents, complaint themes, staff and service user feedback to inform improvement priorities. Systems to feedback learning from triangulated information analysis will form part of the implementation plan.

18 Service user and carer involvement

18.1 The Trust Vision is:

- **"To improve the wellbeing of everyone we serve through delivering services that match the best in the world".**

18.2 This can only be achieved if we ensure our service users' needs are our priority and actively promote the use of advance decisions and individual choice whenever possible. Our violence prevention principles focus on ***CARE***. We cannot achieve our desired outcome without the expertise of our service users and carers. Recognition of expert by experience cannot be considered a best practice initiative; it is an essential element in every aspect of service delivery. Representation of experts by experience (by membership or contribution) will be progressed at a corporate level via the violence prevention strategy group and at a group strategy implementation level.

19 Communication, Trust and Confidence

19.1 Safer services relies on a culture where staff have confidence in and trust the organisational leadership and vice versa. Teams must have confidence and trust in each other. Most importantly our service users and carers must be confident that the services we provide do improve their wellbeing and are matching the best in the world. This strategy is therefore underpinned by communication that is meaningful. Listening to the views of others, taking action promptly and feeding back outcomes is essential if the desired outcome is to be achieved.

- The most effective way to manage violence is to prevent it from occurring
- If a crisis situation occurs, we must reflect, learn and plan for future prevention
- Safer and more therapeutic services can be achieved by working collaboratively; with each other, our service users, carers and partners
- Reducing risk to service users, staff and others is everyone's responsibility

20 Strategic Context

20.1 The NTW violence prevention strategy is informed by a recent review of our organisational compliance with the standards outlined in The Clinical Practice Guidelines for Violence: The Short-term Management of Disturbed/Violent Behaviour in Psychiatric In-patient Settings and Emergency Departments CG25 (National Institute for Clinical Exellence, 2005).

20.2 NICE is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. NICE guidance is based upon systematic reviews and where appropriate meta-analysis of best evidence. Where systematic reviews are not available, then alternative forms of evidence are considered, from single randomised controlled trials gradually decreasing in the strength of the evidence to expert opinion.

20.3 The NICE guidelines on The Short-term Management of Disturbed/Violent Behaviour considered the evidence for the effectiveness of prevention strategies and training.

The evidence base for prevention is somewhat limited and reflects the lack of high quality research in this area, there is however an acknowledgement that there is no singular cause of violence in services and that a range of organisational activities are required to reduce risk.

20.4 As NICE Guideline 25 was published in 2005, and is currently subject to review, the compliance standards were further informed by other key publications and emerging evidence. Compliance statements were mapped into the domains of a 'safer services' model to ensure a structured approach to the process. The compliance review identified many areas of excellent practice and also informed the actions necessary to progress any identified improvements.

21 Strategic Aims

21.1 The Trust does not accept the occurrence of incidents of aggression and violence, and the restrictive interventions required to manage such incidents, as inevitable in our mental health and learning disability services.

21.2 We aim to take forward initiatives to eradicate aggression and violence from our services by implementing an organisational strategy that enhances our understanding of the causes and allows us to progress the interventions necessary to promote a service that is safe for our patients, staff and the wider community.

22 What does this mean for staff working in Northumberland, Tyne and Wear NHS Foundation Trust?

22.1 Our staff are asked to embrace the strategy principles of ***CARE*** and help us to embed them in practice. We have not adopted a violence 'reduction' plan as we believe that any one incident of violence or aggression directed towards our service users, staff or others is one too many. By working collaboratively we increase our chances of achieving our goal to eradicate aggression and violence from our services.

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E **– Empathy: The use of compassion and care to recognise the need to understand each individual's life experience in order to progress**

meaningful and sustainable recovery plans in collaboration with their family/carers.

23 Implementation

23.1 The implementation plan (Appendix 1 and 2) will be allocated to service lines via group Directors. Each service will take forward an implementation plan via a Violence Prevention Steering Group. The VPSG chair persons will attend the overarching strategy group and report on progress on a bi monthly basis.

23.2 The Trust lead for communications will attend the Violence Prevention Strategy Group to support the ongoing communication plan; this will include updates for staff, service users, carers and partners.

24 Monitoring

24.1 An audit framework will be implemented in line with emerging best practice guidance, for example, NICE guidelines, and managed via the governance framework outlined in the strategy document. Research opportunities to further inform the provision of safe and therapeutic services will be sourced and findings shared both internally and externally.

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Implementation plans – Appendix 1 and 2

Appendix 1

Violence Aggression Strategy Group Implementation Plan Commenced:

Development area	Strategy statement	Strategy Group Actions	Responsible lead	Target completion date	Update
Develop staff training and education	The provision of evidence based training that integrates policy into practice in line with bespoke service need is recognised. The need to underpin all training with the values of a caring profession is outlined in a recent review of training. The recommendations outline the need for violence prevention training to be available at induction, mandatory for all disciplines; this has been accepted by the organisation. An implementation plan will be progressed to ensure that the training provided is regularly reviewed and that the needs of clinical services are addressed				

Development area	Strategy statement	Strategy Group Actions	Responsible lead	Target completion date	Update
Clinical support and supervision	Supervision is key to setting and maintaining clinical standards. The transfer of skills into practice requires mentoring and monitoring structures that add value to the staff experience and positively impact on service user care. The development of multidisciplinary supervision structures linked to service objectives will be progressed as part of ongoing workforce planning.				
Post incident support and review	The public health model outlines the need for post incident review to inform prevention planning. The post incident process needs to recognise two elements;				
	1. Organisational learning – To reduce the risk of re-occurrence and inform service improvements;				
	2. Individual / team support – To support individuals (service users, staff and other) who have experienced actual or potential harm as a result of the incident.				

Development area	Strategy statement	Strategy Group Actions	Responsible lead	Target completion date	Update
…continued **Post incident support and review**	An approved model for post incident support and review will be developed by the violence reduction strategy group, implemented and evaluated.				
Recruitment and retention	The formation of teams with the relevant values, skills and knowledge has been observed as an enabler to the prevention of aggression and violence. Teams who have trust and confidence in each other communicate effectively produce better outcomes. The need for MDT ownership of the locality based prevention strategies will be promoted via the strategy launch.				
	Organisational arrangements to recruit staff with the appropriate values are in place, this includes systems to minimise the use of temporary staff. Workforce planning will take account of the skills and knowledge required to develop expertise in services and provide opportunities to develop staff.				

Development area	Strategy statement	Strategy Group Actions	Responsible lead	Target completion date	Update
Therapeutic Environments	The physical care environments are being reviewed as part of the overall service modernisation programme. This includes new build in patient facilities, environmental upgrading and a review of locality based team bases in the community. The therapeutic engagement aspects are addressed via training, supervision, policy and other facets of the safer services model. The Estates plan outlines the ongoing programme of work that is in progress to ensure the physical environments meet with the identified best practice standards.				
Criminal Justice and Police Liaison	Statutory legislation outlines an individuals' right to pursue action via the criminal justice route. National memorandums of understanding have been developed with the NHS and criminal justice services to ensure that appropriate action occurs to manage this process. The Trust has in place liaison arrangements to take forward the required actions. The joint working arrangements and supporting procedures will be reviewed by the violence prevention strategy group to implement and monitor a consistent approach.				

Development area	Strategy statement	Strategy Group Actions	Responsible lead	Target completion date	Update
Organisational boundaries and clear documentation	The concept of zero tolerance can be misplaced in mental health and learning disability services. The complex reasons for violence and aggression need to be understood and interventions applied that are in line with for example, the intent to harm and impact of incidents.				
	However, the recognition that aggression and violence is not acceptable within NTW has to be communicated and posters and information leaflets are in place to ensure everyone using, visiting or working in our services is aware of the boundaries of acceptable behaviour. The posters and leaflets will be reviewed by the violence prevention strategy group and re-launched in consultation with the Trust communications lead.				

Development area	Strategy statement	Strategy Group Actions	Responsible lead	Target completion date	Update
Joint policy development	The prevention of aggression and violence is not a stand alone issue. There are various clinical risk and patient safety policies that link to this and an integrated approach to ensure consistency is outlined in the training review. An overarching clinical risk strategy is being progressed to join the key elements of clinical risk management together and ensure a total organisational approach occurs. This will be monitored by the violence prevention strategy group.				
Interagency working and information sharing	The need to work effectively with other agencies is paramount to effective care delivery in the modern NHS. Gaps in information sharing have been identified as themes in a number of public inquiries in the UK. The need for robust joint working and 'common sense' information sharing is a key enabler in the service users' recovery journey. The need to ensure risk information is shared is essential and arrangements for effective communication need to be in place across services. Due to the complex service infrastructures in NTW groups will be required to review the arrangements in place, identify gaps and prepare action plans outlining the remedial action required and timescales.				

Development area	Strategy statement	Strategy Group Actions	Responsible lead	Target completion date	Update
MDT working and collaborative risk management	'Recognising that the prevention of aggression and violence is everyone's business, collectively and individually we are accountable for the safety and security of all'. As outlined in the violence prevention principles the implementation plans for the strategy need to be implemented at a group level and owned by teams. Each group will progress a prevention plan and will have in place monitoring systems to ensure this is disseminated to teams. Updates will be provided via the violence prevention strategy group, any emerging themes that inhibit progress will be addressed.				
Robust organisational reporting and monitoring arrangements	The need to collate and review service delivery information will be a core role of the group governance structures. Each group will monitor incidents, complaint themes, staff and service user feedback to inform improvement priorities. Systems to feedback learning from triangulated information analysis will form part of the implementation plan.				

Development area	Strategy statement	Strategy Group Actions	Responsible lead	Target completion date	Update
Service user and carer involvement	The Trust Vision is: **"To improve the wellbeing of everyone we serve through delivering services that match the best in the world".** This can only be achieved if we ensure our service users needs are our priority. Our violence prevention principles focus on CARE. We cannot achieve our desired outcome without the expertise of our service users and carers. Recognition of expert by experience cannot be considered a best practice initiative; it is an essential element in every aspect of service delivery. Representation of experts by experience (by membership or contribution) will be progressed at a corporate level via the violence prevention strategy group and at a group strategy implementation level.				

Development area	Strategy statement	Strategy Group Actions	Responsible lead	Target completion date	Update
Communication, Trust and Confidence	Safer services relies on a culture where staff have confidence in and trust the organisational leadership and vice versa, teams must have confidence and trust in each other, most importantly our service users and carers must be confident that the services we provide do improve their wellbeing and are matching the best in the world. This strategy is therefore underpinned by communication that is meaningful. Listening to the views of others, taking action promptly and feeding back outcomes is essential if the desired outcome is to be achieved.				
Communication and Implementation	The implementation plan (Appendix 1) will be allocated to service lines via group Directors. Each service will take forward an implementation plan via a Violence Prevention Steering Group. The VPSG chair persons will attend the overarching strategy group and report on progress on a bi monthly basis. The Trust lead for communications will attend the Violence Prevention Strategy Group to support the ongoing communication plan; this will include updates for staff, service users, carers and partners.				

Appendix 2

Violence Prevention Strategy Operational Implementation Plan

Commenced:
Group:
Service Line:

Development area	Group Actions	Responsible lead	Target completion date	Update	Actual Completion date
Develop staff training and education					
Clinical support and supervision					
Post incident support and review					
Recruitment and retention					
Therapeutic Environments					
Criminal Justice and Police Liaison					

Development area	Group Actions	Responsible lead	Target completion date	Update	Actual Completion date
Organisational boundaries and clear documentation					
Joint policy development					
Interagency working and information sharing					
MDT working and collaborative risk management					
Robust organisational reporting and monitoring arrangements					
Service user and carer involvement					