Quality Standards Advisory Committee 3

Violence and Aggression post consultation meeting

Multimorbidity post consultation meeting

Minutes of the meeting held on 22 March 2017 at the NICE offices in Manchester

Attendees	**Standing Quality Standards Advisory committee (QSAC) members** Jim Stephenson (chair), Darryl Thompson, David Pugh, Julia Thompson, Eve Scott, Madhavan Krishnaswamy, Deryn Bishop, Susannah Solaiman, Karen Ritchie, Ben Anderson, Rhian Last, Lauren Aylott, Keith Lowe **Specialist committee members** Violence and aggression Elena Garralda, Belinda Salt, Nick Nalladorai Multimorbidity Andrew Clegg, Sam Barnett-Cormack, Nina Barnett **NICE staff** Nick Baillie (NB), Nicola Greenway (NG), Ania Wasielewska (AW) [items 5-9], Paul Daly (PD) [items 13-17]
Apologies	**Standing Quality Standards Advisory committee (QSAC) members** Ulrike Harrower, Ann Nevinson, Malcolm Fisk, Gillian Parker, Hugh McIntyre **Specialist committee members** Violence and aggression Faisil Sethi, , Anthony Bleetman **Multimorbidity** Carolyn Chew-Graham

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 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.	
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 topics under consideration at the meeting today. The Chair asked the specialist committee members to declare all interests. The following interests were declared: <u>Standing committee members</u> <u>Eve Scott</u> Eve declared she now works for Salford Royal Foundation Trust. <u>Rhian Last</u> Rhian declared the following new interests. Programme Advisor / Presenter for Practice Manager / Practice Nurse Development Programme – 12 month project in NW, a collaboration of Education for Health, Experience Led Care and NHS Alliance – funded by NHS England Facilitator on Group Consultations for GPNs - 12 month programme run in NW- run by Experience Led Care and funded by NHS NW HEE – on behalf of my employer, Education For Health	

Agenda item	Discussions and decisions	Actions
	TEVA: speaker at Respiratory Conference held on 3rd and 4th March 2017 – on behalf of my employer, Education For Health Cogora: Nursing in Practice Conference: Liverpool 2nd February 2017, speaker session – on behalf of my employer – Education For Health Mark Allen Group – four speaker sessions at Primary Care Nursing Expo – held on 1st February – London – on behalf of my employer - Education For Health Specialist committee members • Elena Garralda Elena has shareholdings in pharmaceutical companies, but the manufacturers do not produce drugs relevant to the topic for discussion. • Nick Nalladorai None. • Belinda Salt None. **Minutes from the last meeting** The committee requested that the minutes be circulated and reviewed after the meeting.	
4. QSAC updates	NB updated standing members regarding the new QSAC arrangements.	

5. Recap of prioritisation exercise	AW and NG presented a recap of the areas for quality improvement discussed at the first QSAC meeting for violence and aggression: At the first QSAC meeting on 16 November 2016 the QSAC agreed that the following areas for quality improvement should be progressed for further consideration by the NICE team for inclusion in the draft quality standard: • Anticipating violence and aggression	

	• De-escalation • Prevention interventions • Using restrictive interventions The full rationale for these decisions is available in the prioritisation meeting minutes which can be found here	
5.2 and 5.3 Presentation and discussion of stakeholder feedback and key themes/issues raised	AW and NG presented the committee with a report summarising consultation comments received on violence and aggression. The committee was reminded that this document provided a high level summary of the consultation comments, prepared by the NICE quality standards team, and was intended to provide an initial basis for discussion. The committee was therefore reminded to also refer to the full list of consultation comments provided throughout the meeting. The committee was informed that comments which may result in changes to the quality standard had been highlighted in the summary report. Those comments which suggested changes which were outside of the process, were not included in the summary but had been included within the full list of comments, which was within the appendix. These included the following types of comment: • Relating to source guidance recommendations • Suggestions for non-accredited source guidance • Request to broaden statements out of scope • Inclusion of overarching thresholds or targets • Requests to include large volumes of supporting information, provision of detailed implementation advice • General comments on role and purpose of quality standards • Requests to change NICE templates A specialist committee member who could not attend the committee meeting submitted comments prior to the meeting. AW presented these comments following the presentation of the consultation comments for each of the statements for the committee to consider. The committee discussed the general themes identified from the consultation comments. Positive: - Quality standard overall well received - General feedback was that the appropriate areas for quality improvement had been identified. - Most of the measures generally felt to be feasible - No concerns about data collection - existing data sources suggested	

	- No concerns regarding resource impact have been raised – stakeholders discussed potential cost savings instead For consideration: - Focus only on people with mental health problems – discriminatory and reinforcing stigma - People with learning difficulties should not be excluded - Communication and transfer of information between organisations supporting people with mental health problems – should be made more prominent throughout the QS - The committee also discussed the issues raised by stakeholders around the quality standards linking violence and aggression with people with mental health problems only. The guideline title gives much more details and makes the population a bit more clear. The committee asked the NICE technical team to review QS title and look into alternatives	**NICE technical team to review QS title and look into alternatives**
5.4 Discussion and agreement of final statements	The committee discussed each statement in turn and agreed upon a revised set. **These statements are not final and may change as a result of the editorial and validation processes.**	

Draft statement 1	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
People in contact with mental health services who have been violent or aggressive are involved in identifying their triggers and early warning signs.	• Identification of triggers and early warning signs should inform care planning, organisational culture and practice. • Context to the episodes should be captured when collecting this information. • Prevention 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	Committee discussed the use of word “involved” as it was felt that it read that something is done to people rather than service users being an active participant in their own care. Supporting people to be involved in this process was felt more appropriate. They agreed to change the statement wording to ‘are supported’ and change ‘their’ to ‘ the’. The committee wanted to highlight the importance of the context including the environment for examples wards and staffing as this might be the trigger and agreed to add a definition of triggers from the full guideline. The committee agreed with stakeholder comments that identified triggers and early warning signs should inform care plans and that it was important that the information from the care plan is shared. The committee felt care plans are already	**Y** **Amend statement wording and revise supporting sections**

	Consultation question 5 responses; statement should apply to: - all health services - all settings where mental health, health and social care services are provided - primary care, some acute care environments, local authority and voluntary sector, - prisons - non-NHS secure settings for children and young people such as secure children's homes, secure training centres and young offender institutions	shared with GPs but not necessarily other services such as accident & emergency staff and that this should be highlighted in the supporting sections. De-escalation passport – not possible, better as part of a care plan. The committee discussed consultation responses which were supportive of extending the application of statements 1 and 2 to more settings. The committee agreed that whilst it would be beneficial for more services to be aware and implement the statements, it would be very difficult to measure and it would be beyond aspirational for some settings.	Keep the population as per draft quality standard.
Draft statement 2	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**
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.	• Context needs to be considered – environmental and staffing issues need to be recognised as contributing factors • De-escalation passport - information sharing between health and care organisations • Service users should be involved in developing preventive as well as coping strategies at this point • Focus on previously used de-escalation techniques - limit the use of more progressive techniques • Issues around the title and potential stigmatising message	The committee discussed whether it was appropriate to use de-escalation and restrictive interventions in the same sentence. The committee heard how de-escalation is relevant for a wide spectrum of violent and aggressive behaviours and there is a need to apply it throughout the spectrum even when the restrictive interventions are used. It was felt both areas were important to highlight in the statement but that the rationale needs to show the link between de-escalation, restrictive interventions and the advanced statements. The committee agreed minor changes to the statement wording from "are involved" to "are supported" to be consistent with statement 1.	**Y** **Amend statement wording and revise supporting sections**

Draft statement 3	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
People with a mental health problem who are manually restrained have their physical health monitored during and after restraint.	• Challenging circumstances - using equipment, collecting data and results is difficult when the violent behaviour is taking place • Only information based on observation can be gathered whilst the person is being restrained • Results not meaningful due to physical exertion • Statement should focus on: - minimising the duration of restraint - monitoring only in the case of prolonged restraint • Trauma and psychological harm should be addressed as well Consultation question 6 responses: - physical observation in line with NEWS - National Early Warning Scores (respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate, level of consciousness) - additional observations may be needed depending on service users' health - pulse oximetry could be used for monitoring vital signs - different concerns and monitoring associated with prone vs supine restraint	The committee discussed stakeholder's suggestions that physical observations should be done in line with the National Early Warning Scores (NEWS). It was agreed that in practice this would be too difficult to do during restraint but should be done as a minimum after restraint has happened. The committee felt it would be too prescriptive to differentiate the level of monitoring based on the level of restraint. However it was expected that the level of monitoring during restraint may differ depending on the length of the restraint. They also discussed monitoring being difficult to do when someone is in seclusion. The committee agreed there should be two separate ways of monitoring physical health - NEWS to be used for the definition of monitoring physical health after restraint as a minimum and the current definition included in the QS to be used for the definition of monitoring physical health during restraint. It was suggested that mechanical restraint should be included in the statement. NICE guideline recommendations on mechanical restraint are only applicable to high-secure settings and therefore it was agreed could not be included in the statement. It was agreed to highlight in the rationale that restrictive interventions should be used for the shortest amount of time. Committee discussed stakeholders suggestions and agreed that there would be a distinction between what should and could be monitored during and after physical restraint. It was agreed that the statement does not need to be changed but definitions should reflect the differences.	**N** **Keep statement wording but revise supporting sections**

Draft statement 4	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
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.	• Need to define vital signs – external observations of respiratory rate, hydration and level of consciousness may only be feasible • Rapid tranquillisation – definition questioned • Additional measures suggested: history of rapid tranquillisation, advanced statements, discussions recorded within the care plan	The committee discussed stakeholder's comments about the definition of rapid tranquillisation and whether this includes oral medication and how it aligns with the definition from the mental health act. The committee heard how this was discussed in detail during the guideline development process and agreed it should not be changed from that defined in the guideline. The committee questioned how easy in practice it would be for these checks to take place for people in seclusion. It was agreed this population should be highlighted in the supporting information as additional considerations may be required. The standard incident reporting system can be used to capture the measures within the statement.	**N** **Keep statement wording but revise supporting sections**
Draft statement 5	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**
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.	• Statement on debrief supported • **Immediate** debrief challenged by most stakeholders - may be taken too literally - time is needed before the person and members of staff are ready - quality of debrief is crucial - important who carries it out - debrief should be offered and only done with people who want it • Content of the debrief - review of the care plan, analysis of the participants and lessons learned for staff	The committee discussed the meaning of the term immediate and felt a timeframe could not be added to the statement as it would vary depending on the individual. For example it may take several hours for an individual to recover from rapid tranquillisation. It was agreed to keep immediate in the statement to highlight that this is something that should be done quickly but to add a definition stating that this should be when the person and staff are ready, supported by recommendation 1.4.58. The committee discussed the interpretation of the de-brief. It was agreed that de-brief needs to be done immediately at organizational level but individuals involved in the incident have an opportunity to be involved and have their say only when they have regained their composure and all the	**Y** **Amend statement wording and revise supporting sections**

		immediate risks and health concerns are addressed. The committee discussed an option of structural measure focused on the organisation. The committee agreed the statement should remain person centered but should be amended to say that people have the opportunity to be involved in rather than “have a de-brief”. Committee heard that preferences in regards to how quickly the person wants to be approached and discuss the situation post incident should align with advanced statement. The committee felt it was important to highlight that the purpose of the review was to make the person feel safe and that services learn from the incident.	

Additional statements suggested	**Committee rationale**	**Statement progressed (Y/N)**
Principles	Discussed at prioritisation meeting but not progressed because that is the principle of the whole guideline and this is included in several rationales throughout the QS.	**N**
Staff attitude	Underlying principle and not appropriate for statement development.	**N**
Staff training	It is assumed all staff undertaking the actions are appropriately trained.	**N**
Staff welfare	Staff welfare is an outcome of decreased violence and aggression.	**N**
Systemic and psychological interventions	No guideline recommendations on which to base a statement. Scope of the source guidance is on short term management – outside the scope of the quality standard.	**N**
Hate related crime	Outside the scope of the quality standard.	**N**
Immediate violence	Comment was about staff skills No guideline recommendations on which to base a statement.	**N**

Need for additional resources and facilities	Guideline development group reviewed this area as part of the guideline development process but could not recommend any actions on which to base statements	**N**

6. Resource impact	Stakeholders highlighted areas for cost-savings for example staff sickness and reduced length of stay rather than resource impact. The committee agreed the 5 statements prioritised would not have a significant resource impact.	
7. Overarching outcomes	The NICE team explained that the quality standard would describe overarching outcomes that could be improved by implementing a quality standard on violence and aggression. The committee suggested the following outcomes to be considered for this quality standard; reduced length of stay, rates of seclusion. They also felt it was important that service user experience was listed as the main outcome of the quality standard. It was agreed that the committee would contribute further suggestions as the quality standard was developed.	Review the proposed overarching outcome measures and amend the quality standard accordingly
8. 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. The committee highlighted several groups for consideration including prisoners and Caribbean men who may have a higher risk of mental health problems and transgender or people with a history of trauma where adjustments made need to be made. It was agreed that the committee would contribute other suggestions as the quality standard was developed.	Review the equality groups raised and amend the quality standard and equality impact assessment accordingly.
9. Next steps and timescales (part 1 – open session)	AW outlined what will happen following the meeting and key dates for the violence and aggression quality standard.	

	Multimorbidity	
10. 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.	
11. Welcome and	The Chair welcomed the public observers and reminded them of the code of conduct that they were	

code of conduct for members of the public attending the meeting (public session)	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.	
12. 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 under consideration at the meeting today. The Chair asked the specialist committee members to declare all interests. The following interests were declared: <u>Standing committee member</u> • <u>Susannah Solaiman</u> Declared an interest relevant to the topic under consideration that she is the clinical lead for integrated care. <u>Specialist committee members</u> • <u>Andrew Clegg</u> Andrew has led the development and validation of an electronic frailty index (eFI) that uses routine primary care electronic health record data to identify and severity 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. There is no financial interest in the implementation or use of the eFI. • <u>Sam Barnett-Cormack</u> Sam has made public statements on social media related to healthcare for people with multiple conditions. • <u>Nina Barnett</u> – Shareholder for a company that produces patient information videos. – Teaches health coaching for a company that receives funding from health companies and the NHS. – Produces training packages for care homes with Aged Care Channel (ACC). – Publishes narrative articles related to multimorbidity and specialist polypharmacy.	

	– Supporting Aged Care Channel with filming to provide information on good practice for care staff in care homes. – Talk on respiratory medications and adherence, funded for by drug company. – Talk at upcoming congress on medications and dysphagia, aphasia and patient centred polypharmacy. Organisation receives funding from pharmaceutical companies. – Talk on pharmacy management on medicines optimisation and adherence. Organisation receives funding from pharmaceutical companies.	

13. Recap of prioritisation exercise	PD and NG presented a recap of the areas for quality improvement discussed at the first QSAC meeting for multimorbidity: **At the first QSAC meeting on 16 November 2016 the QSAC agreed that the following areas for quality improvement should be progressed for further consideration by the NICE team for potential inclusion in the draft quality standard:** • Identification • Frailty • Assessment – goals, values & priorities • Reviewing medicines and other treatments • Management plan The full rationale for these decisions is available in the prioritisation meeting minutes which can be found here	
13.2 and 13.3 Presentation and discussion of stakeholder feedback and key themes/issues raised	PD and NG presented the committee with a report summarising consultation comments received on multimorbidity. The committee was reminded that this document provided a high level summary of the consultation comments, prepared by the NICE quality standards team, and was intended to provide an initial basis for discussion. The committee was therefore reminded to also refer to the full list of consultation comments provided throughout the meeting. The committee was informed that comments which may result in changes to the quality standard had been highlighted in the summary report. Those comments which suggested changes which were outside of the process, were not included in the summary but had been included within the full list of comments, which was within the appendix. These included the following types of comment: • Relating to source guidance recommendations	

	• Suggestions for non-accredited source guidance • Request to broaden statements out of scope • Inclusion of overarching thresholds or targets • Requests to include large volumes of supporting information, provision of detailed implementation advice • General comments on role and purpose of quality standards • Requests to change NICE templates General comments and themes identified from the consultation comments were then presented to committee. • Quality standard was well received • Appropriate areas for quality improvement had been identified • Is the standard measurable? • Contrasting views on whether the standard is achievable given the resources available • Themes included: o Emphasis and wording (balance between mental health and physical conditions; focus on GP practices; role of carers & relatives; and collaboration & partnership with patient) o Multimorbidity & frailty (overlap, distinctions, confusion, treatment by draft statements 1 and 2) o Alignment with GP contract	

Draft statement 1	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)

Adults with multimorbidity are identified by their GP practice	• Multimorbidity v frailty
	  • Overlap but can be exclusive
	  • Relationship with statement 2 / eFI
	  • Definition: 1 LTC must be physical?
	• Align with GP contract (routine frailty identification)
	• Information needs to be consistent and shared
	• Explicit about how to identify (tools &
		The guideline describes a 2-step approach to identifying patients. Step 1 involves identifying people with multimorbidity. Step 2 involves identifying the sub-group of patients who would benefit from an approach to care that takes account of multimorbidity.
		
		Draft statement 1 covers both steps. Committee discussed both steps but agreed the statement should focus on the first step. Therefore agreed the statement wording should be retained but the audience descriptors and definitions should remove reference to eFI and other tools
			N
			Retain statement wording but revise audience descriptors and rationale.

	systems) • Audience descriptors too narrow – extend beyond GP practice • Wording does not reflect collaborative care • Resource impact	It was agreed the rationale should align more closely with the wording of the guideline to change additional support to an approach to care that takes account of multimorbidity.	
Draft statement 2	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**
Adults with multimorbidity who are assessed for frailty are evaluated using gait speed, self-reported health status or a validated tool	• Statement should apply to people aged over 65? • Confusion between frailty and multimorbidity • How should frailty be assessed? No reference to: • eFI (contrast to statement 1) • clinical frailty scale • comprehensive geriatric assessment • NHS England approach • Audience descriptors should be widened	Remove statement as the statement as worded is not a key area for quality improvement given changes in the system with the introduction of the GP contract and there are no other recommendations in this area to amend the statement.	
Draft statement 3	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**
Adults with multimorbidity are asked about their goals, values and priorities.	• Expand goals, values & priorities • Need for regular review • Conversations provide other opportunities • Professionals: Extend beyond GPs & practice nurses • Recording, documenting & sharing • Advance care planning • Advocacy • Wording: Patient not a true partner?	The denominator in the process measure and the target population described by the statement are not accurate. They should relate to those who are receiving an approach to care that takes account of multimorbidity. Change denominator of process measure to those with the management plan. The statement wording needs to portray the person with multimorbidity as partner and reflect a collaborative approach. Change 'asked' to 'are supported to/are involved	**Y** **Amend statement wording and revise supporting sections.**

	• Resource impact: Not achievable or resource neutral? • Overlap with statement 5? • Yes, but retain 2 statements	in/encouraged' to clarify and reorder statement wording to "values, priorities and goals". The committee agreed the professionals should extend beyond GPs and practice nurses so agreed to add community pharmacists, HCA, secondary care to audience descriptors. It was questions whether this could link with statement 4 and the role of the coordinator? Extend equalities issues to reference advocacy. There can be a culture of not expecting to be asked. The text needs to be broader and recognise advocacy as relevant to more than just those with communication difficulties/LD. May be some evidence that fewer, longer appointments can save time in the long term. The draft depicts goals, values and priorities from a clinical perspective. It needs to include broader life goals. It should reflect carers, advocacy and person-centred care. It should cover sharing to facilitate shared decision making and include broader well-being outcomes. All of which should be captured in the rationale.	
Draft statement 4	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**
Adults with multimorbidity know who is responsible for coordinating their care.	• Wording: Not inclusive & cooperative • Align with NHS England approach • Adults with multimorbidity or frailty • Information sharing • Separate care coordinator role • Recognise others involved in decision making	The target population and the denominator in the process measure are not correct. They need to reflect those who are receiving an approach to care that takes account of multimorbidity. It was agreed to change denominator to those with a management plan. The audience descriptors need to be wider and could include practice-based pharmacists, however it needs to be someone with an ongoing relationship with the individual and that	**Y** **Change statement wording to reflect target population. Revise supporting sections in line with committee decisions.**

		wouldn't be a community pharmacist. The committee discussed the role of carers and their role in coordinating care. It was felt the key issue is that there is a professional taking this on rather than the patient or carer themselves. The supporting information needs to reflect that this should be everyone so the adult, their carer and the professionals, so sharing who is coordinating care.	
Draft statement 5	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**

Adults having a review of their medicines and other treatments for multimorbidity discuss whether treatments can be stopped or changed.	• Focus on medicines
	  • health needs?
	  • wider treatment burden?
	  • social care needs?
	• Statement implies there is a treatment for multimorbidity?
	• Reviews supported
	  • Need to be regular
	  • Not just stopping / changing treatments
		Important that it does have a focus on medicines and other treatments so it gives professionals a chance to step away from single condition guideline. A definition of other treatments to be added to the statement to highlight this area.
		
		It was agreed the reviews will take place in GP practices and that they should be done regularly. This should be included in the rationale but it is not possible to specify how often it should be. A management plan would have how often the review should take place. The rationale should also reference the impact of treatment burden as part of conversations as well as medicines adherence.
		
		Advocacy was highlighted as an important area relevant for this statement to ensure people's views and preferences are followed and should be referenced as per statement 3.
		
		It was discussed how one conversation may be used for several statements in practice but that it was important the different aspect of the conversation were highlighted in the separate statements.
			Y
			Revise rationale and audience descriptors.

Additional statements suggested	Committee rationale	Statement progressed (Y/N)
Supporting people to self manage	Considered at prioritisation, covered by patient experience quality standard.	**N**
Supporting families and carers	Considered at prioritisation, covered by the Care Act.	**N**
Statement to reflect the links between multimorbidity and psychological status	No recommendations on which to base a statement.	**N**

14. Resource impact	No resource impact.	
15. Overarching outcomes	The NICE team explained that the quality standard would describe overarching outcomes that could be improved by implementing a quality standard on violence and aggression. It was agreed that the committee would contribute suggestions as the quality standard was developed.	
16. 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.	
17. Next steps and timescales (part 1 – open session)	NICE team outlined what will happen following the meeting and key dates for the violence and aggression quality standard.	
18. Any other business (part 1 – open session)	No other business. **Date of next meeting HIV Testing and Rehabilitation after critical illness: 17 May 2017**	