NHS
National Institute for
Health and Clinical Excellence

Self-Harm, Quality Standard Topic Expert Group

Minutes of the TEG3 meeting held on 5th March 2013 at the NICE Manchester Office

Attendees	Navneet Kapur (NK) (Chair), Carolyn Chew-Graham (CCG), Amrit Sachar (AS), Sarah Rae (SR), Safi Afghan (SA), Kate Hunt (KH), Anne Hicks (AH), Anthony Cox (AC), Paul Wilkinson (PW) **NICE Staff** Adrian Johnson (AJ), Craig Grime (CG), Beth Shaw (BS), Rachel Neary (RN), Lee Berry (LB) **External attendees** Azim Lakhani (ALa) (Head of Clinical Analysis Research and Development, Health and Social Care Information Centre) **Observers** Alexia Biesty (NICE), Dominick Moran (NICE)
Apologies	Janet Youd, Caroline Lea-Cox, Dawn Hardman, Gemma Trainor **NICE Staff** Cheryl Thorne

Agenda item	Discussions and decisions	Actions
1. Introductions and apologies, minutes of last meeting	NK welcomed the attendees, noted the apologies and reviewed the agenda for the day. The group confirmed that the minutes from the meeting held on 11th October 2012 were an accurate record.	
Declarations of interest	NK asked the group whether they had any new interests to declare since the last meeting and none were declared.	
2. Review of progress so far and objectives of the day	BS reviewed the progress made on the quality standard (QS) so far. She advised the group that the main objectives of the day were to discuss the results of the consultation and agree the quality statements and associated measures for progression into the final QS. BS reminded the group that the QS should only consist of aspirational statements addressing key areas of quality or variations in care. The group was also reminded that the QS should be as concise as possible and should not include anything that is standard practice. BS reminded the TEG that further changes may be made to the QS following the meeting, subject to discussion with and agreement of the TEG Chair and following Guidance Executive. BS confirmed that the group will have the opportunity to see and comment on the final version of the QS before publication.	
3. Support for commissioners and others using the quality standard	AJ outlined the role of the NICE Costing and Commissioning team and advised the group that they will develop a support document for commissioners and other users to accompany the QS. He stated that the purpose of this document is to help commissioners and service providers consider the commissioning implications and potential resource impact of using the QS. AJ advised the group that they may need to provide input during its development. He also told them that they will have the opportunity to comment on the document. AJ asked the group to contact him or CT if they have any questions or would like to contribute.	TEG members to contact AJ/CT if they would like to contribute to the commissioning document.

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4. Presentation and discussion of consultation feedback	CG gave a brief overview of the consultation comments received and highlighted that there had been positive feedback. Common themes included being specific about the settings and staff that each statement could apply to. CG advised the group that they would consider statement-specific comments received from the consultation as they discussed each statement. CG also highlighted that responses will be formulated to comments received from registered stakeholders and these responses will be published on the NICE website alongside the final quality standard.	
5. Presentation, discussion and agreement of final statements	CG presented each of the statements and the responses to them from the stakeholders. The group then discussed each statement and the feedback in turn. **Statement 1 – People who have self-harmed are cared for with compassion and the same respect and dignity as any patient.** The group discussed this and agreed that is an important statement and should be included in the final quality standard. It was also agreed that within the definitions it should cover all staff not just clinical staff. No changes made to the statement. **Statement 2 - People who have self‑harmed have an initial assessment of their physical health, mental state, social circumstances and risk of suicide.** The group discussed this in connection with statement 3 and considered overlap between the two statements. The group agreed that this statement should be included in the final standard but should be expanded to include safeguarding concerns and risk of repetition. Provisional re-draft: *People who have self‑harmed have an initial assessment of their physical health, mental state, safeguarding issues, social circumstances and risk of repetition or suicide.* **Statement 3 - People who have self‑harmed have an assessment that specifically considers safeguarding issues, including risks**	

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	to themselves and others. The group agreed that safeguarding concerns should be addressed by the initial assessment and comprehensive assessments that are covered by statements 2 and 5. This statement was therefore removed. **Statement 4 - People who have self‑harmed are cared for on a documented care pathway.** The group discussed this statement and agreed it was a service based statement, rather than a person-centred statement. The group felt that unless individual actions could be clarified, this shouldn't be included in the final standard. **Statement 5 - People who have self‑harmed are offered a comprehensive psychosocial assessment with a specialist mental health professional.** The group discussed whether this statement should measure the offer or the receipt of psychosocial assessments. It was also discussed that any intervention or assessment should always undertaken by an appropriate specialist mental health profession therefore this doesn't need to be in the statement. It was also agreed that safeguarding concerns should be reflected in the definitions section. Provisional re-draft: *People who have self-harmed receive a comprehensive psychosocial assessment* **Statement 6 - People in acute care who have self‑harmed receive the supervision they need in a setting that has been assessed for environmental risks.** The group discussed this statement; they agreed it should be separated into two statements to ensure one concept per statement. Supervision – the group agreed that people who have self-harmed should be 'monitored and supported' rather than 'supervised', as this is more patient centred. It was agreed this is important as it can reduce further self-harm whilst in the NHS setting.	

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	Environment – this was discussed, and as with the supervision this can reduce the possibility of further self-harm. It was agreed that this relates to more than the standard NHS litigation reports and therefore it was agreed that a quality a statement should be included. The group felt that both statements applied only to patients in NHS settings, which was agreed to include emergency departments, acute wards and GP surgeries. Provisional re-draft: *People presenting with self-harm [whilst in NHS settings] receive the monitoring and support they need to reduce the [immediate] risk of further self-harm.* *People presenting with self-harm [in NHS settings] are cared for in a safe physical environment to reduce the opportunity for further self-harm.* The group discussed the prefix that should be used for the next statements as they all apply to the same group of people. The group agreed to use *People requiring on-going care following an episode of self-harm* as this accurately describes the group. **Statement 7 - People who accept longer‑term support for self‑harm are involved in developing a care plan that includes risk management.** This was discussed and the group agreed that it needed to be clarified whether the focus was on the involvement in care planning or the inclusion of risk management. It was felt that the involvement of patients in developing care plans is covered by the service user quality standard and therefore a separate statement isn't required. The statement would instead focus on risk management as an important area that can reduce the further episodes of self-harm and it was agreed it was important to be collaborative so that the patient can recognise risk management. Provisional re-draft: *People requiring on-going care following an episode of self-harm have a collaboratively developed risk management plan* **Statement 8 - People who accept longer‑term support for self-harm discuss with their lead professional the potential benefit of**	

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	psychological interventions specifically structured for people who self‑harm. This was discussed and the group agreed that it was an important statement, however the group felt this placed the emphasis on the patient to lead the discussion, this was re worded so that it ensured that the emphasis was on both the lead professional and patient to discuss the possible benefits. Provisional re-draft: *People requiring on-going care following an episode of self-harm and their lead professional discuss the potential benefit of psychological interventions specifically structured for people who self‑harm.* **Statement 9 - People who accept longer‑term support for self‑harm are involved in producing a written plan about their continuing care when moving between services.** This statement was discussed and the group agreed it was an important area and was distinct from the standard transition of services covered by the patient experience QS. It was agreed that this needed to be specifically covered in a care plan and as with statement 7 this needed to be collaboratively developed. Provisional re-draft: *People requiring on-going care following an episode of self-harm and transferring between and within mental health services have a care plan that specifically addresses the transition.* CG presented the additional areas suggested by stakeholders, these were, safe prescribing, harm minimisation, remote services, the criminal justice system, people at high risk of self-harm and associated behaviours. The group discussed these and concluded that safe prescribing was basic good practice and therefore no statement was progressed. Harm minimisation was discussed and the group agreed that the evidence base was not strong enough to develop a statement with specific actions. The other areas were agreed to be outside the scope of the QS and therefore not eligible for development as quality statements.	

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8. Summary of final statements	CG presented a summary of the revised statements to the TEG.	
9. Equality impact assessment	CG advised the group that an equalities impact assessment would be completed, for the following reasons: • To confirm that equality issues identified have been considered and appropriately addressed. • To ensure that the outputs do not discriminate against any of the equality groups • To highlight planned action relevant to equality • To highlight areas where statements may promote equality	TEG to flag and equality issues with the technical team
10. Next steps	RN then joined the meeting and outlined the next steps, including key dates in the QS development process. The TEG was informed of the organisations that had expressed an interest at consultation stage in endorsing the quality standard. The group discussed that the consultation for the group was over the Easter break and due to leave this would be difficult to respond, RN agreed to liaise with Esther to check if timelines could be adjusted slightly to avoid this.	RN to liaise with EC re timelines
11. AOB	NK thanked the group and CG in particular for their hard work and closed the meeting.	