Mental Health PSEG Meeting
Wednesday 9th September 2015

Attendees:					
Dr Ben Thomas - **Chair**	√	Vanessa Gordon	√	Helen Smith	√
Alan Worthington	√	Joanne McDonnell	√	Fiona Grossick	√
Lauren Mosley	√	Sarah Markham		Sophie Corlett	√
Robert Tunmore	√	Richard Webb (observer)	√		
Paul Farmer	x	Louis Appleby	x	Elizabeth England	x
Ray Walker	x	Ursula Rolfe	x	Caroline Hacker	x
Ian Hulatt	x	Joan Russell	x	Alan Metherall	x

No.	NOTES	ACTIONS
A.	**Welcome and apologies** A large number of apologies were received for the meeting following the change of date. It was agreed that the date of the next meeting should be sent as a diary invitation to members, rather than relying on them checking the minutes for details.	**Secretariat** to send diary invitation for next meeting
B.	**Notes from the last meeting** The minutes of the previous meeting were accepted. All actions have either been cleared or appear on the agenda.	
C.	**Role and function of the Patient Safety Expert Group** During the discussion the following points were made: • All PSEGs will be moving to NHS Improvement, but the role and functions under the new organisation are still being determined. The group's remit covers mental health patients in all NHS Funded settings, terms of reference discussed • The group discussed various formats that were available to notify the NHS about patient safety issues. Such as patient safety alerts • Cause for concern messages can be sent to regions if an incident is raised. This will seek evidence of the investigation that took place, which can then be used to highlight issues. Developing newsletters to highlight 'unusual stories' relating to people with mental health issues may also help to draw attention to these. • In order to make the appropriate changes, frontline staff would welcome more information about what improvements in patient safety look like. How to support organisations to make the change is just as important as telling them what needs to be done. Linking with collaboratives would help to achieve this. The group welcomed the suggestion that an AHSN Collaborative Leader be invited to a future meeting to give an overview of their work, and to discuss how the PSEG could support collaboratives. An update on the zero suicide collaborative work may also be of interest. • Discussions topics could be around major issues highlighted by data reviews and the MH Dashboard information. An example was the Crisis Care work in London looking at transport commissioning procedures for the transfer of mental health patients. The group agreed that inviting speakers to meetings to hear about similar work would be a good way to influence outcomes, and help them keep in touch with front line activities.	**VG** to forward ToR to Rob Tunmore **HS/VG** to liaise with AHSN Collaborative to identify guest speaker

	• Use social media to highlight mental health patent safety issues, inform people when the meeting minutes are available, and send information on how to report patient safety concerns to monitoring organisations. • Carers sometimes feel that support is lacking when dealing with mental health patients, and no action taken when an alarm is raised with a professional. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness recommends that services should work with families (and friends) to reduce the risk of suicide.	Before the next meeting, **VG** and **BT** to discuss the MH Dashboard with Paul Farmer
D.	**Feedback from Patient Safety Steering Group** Other PSEGs tackling big safety issues in their specialisms and providing documents for staff. Presentation by Liz Mears, Chief Executive North West Coast AHSN, on Collaboratives. Chairs agreed PSEGs should work more closely with them.	
E.	**Mental Health Homicides: national actions** The leads are currently developing clear actions and deliverables for March 2016, which includes reviewing governance structures for Independent Investigations. This work is closely linked to the Serious Untoward Incident Framework. A steering group is being set up where Regional Directors of Nursing will review national recommendations arising from investigation reports. It was suggested that these recommendations should be shared with the group so they can help ensure any learning is implemented. Sarah Markham reported that Veritas doing follow ups to see if Trusts have implemented report recommendations. Early indications are that whilst themes remain the same, the underlying issues move on. Supporting the development of a safety culture is better than regulating on what has gone wrong. Members felt this could be addressed by promoting continuous learning rather than fire-fighting.	**JMcD/RT** to circulate draft Independent Investigations governance paper for comment **VG** to discuss sharing of learning from homicide reviews with the Director of Patient Safety
F.	**Serious Untoward Incident Framework update** Lauren Mosley reported that the National Framework is aimed at all NHS funded providers. It sets out the circumstances when incidents should be reported, including deaths and incidents that others could learn from. The methodology is now more robust and systematic, and the need to involve patients and families from the outset when an investigation takes place has been reinforced. The relationship between providers and commissioners was also reviewed to ensure action plans are completed by the most appropriate person. The next phase is to build a detailed commissioner toolkit for each stage of the process, which should help commissioners to make the right decisions. The Framework should support Trust's to link actions to their overall improvement agenda.	Any queries regarding the Framework should be sent to Lauren Mosley
G.	**Update from the Mental Health Taskforce** To help inform decisions about priorities for the new strategy, the Taskforce sought the views and expertise of people with personal experience of mental health problems, as well as reviewing clinical and economic evidence. Over 20,000 people responded to the consultation and a public engagement findings report was published. The final report will be published in October, slightly later than planned.	
H.	**Patient Alert: action after observations** A paper on '*the importance of performing physical observations during and after physical intervention/restraining*' will go to the Patient Safety Steering Group in October. It has been updated to cover all NHS funded providers, not just Mental Health Trusts. Members were invited to send any comments to Vanessa Gordon.	Members to send any comments to Vanessa Gordon by end September

I.	**Mental Health Collaborative South** (*This replaced the Academic Health Science Network update*) Helen Smith explained the background to the South Improving Safety in Mental Health Collaborative, and how it operates. The Collaborative follows a US model where people are brought together to tackle a problem. All Mental Health services in the South are involved, and meet as learning sets for 2 days to share success and problem solve. Networks have also been set up to enable data sharing and connections between organisations with similar issues. The Collaborative is run by a local team as a faculty with 4 workstreams: leadership for safety; safe and reliable care; safer medications management; and patient and family centred care. Each workstream has SMART (specific, measurable, achievable, realistic, time bound) targets. The data is used to engage staff to make improvements, and there is evidence to show this has been effective approach. A strong steer from the centre would be valuable, as it would enable collaboratives to focus on national issues as well as local ones. A lot of work is being done on patient safety outside of the collaboratives which also needs to be shared. The information gained could be reported to the National Patient Safety Steering Group via the PSEG. Ii is important to get organisation leaders to engage with the changes that frontline staff want. All processes need to be reliable in order to achieve the required outcomes. This PSEG could bring all good mental health patient safety work together and disseminate it. Members agreed to review how to do this after the move to NHSIQ.	
J.	**Date of Next Meeting** 24th November from 13:00 to 15:00, Skipton House, Meeting Room 138B	**VG** and **PF** to agree a new date for the December meeting
K.	**Any other business** *Patient representation on the group* An advert was sent on PSEG's behalf by MIND but very little response. The deadline may be extended. Members were encouraged to bring the vacancy to the attention of their networks. *Suicide Prevention* VG reported that new standards are being included in the Suicide Prevention tool regarding discharge planning. *Sexual Safety Tool* As the tool is aimed at front line commissioners, it needs to be readily accessible. There are a number of options and VG would welcome views on which would be best. *Patient Safety Thermometer* The take up in Mental Health Trusts is lower than expected. It was noted that some Trusts do more than the minimum requirements so do not see any advantages to signing up. The PSEG will consider how to actively promote the benefits.	**VG** to send Patient Representative advert to members **VG** to ask Joan Russell about extending the vacancy deadline **VG** to send Sexual Safety Tool website options for agreement on best to host