

OPEN BOARD OF DIRECTORS

8th February 2017

Item 11ii

TITLE OF PAPER	Quality Assurance Committee Summary Report to the Board of Directors in respect of Significant Issues
TO BE PRESENTED BY	Mr Mervyn Thomas, Chair, Quality Assurance Committee Non-Executive Director
ACTION REQUIRED	For assurance

OUTCOME	To report items of significance discussed at Quality Assurance Committee on 23 rd January 2017
TIMETABLE FOR DECISION	None required
BAF OBJECTIVE No and TITLE	
LINKS TO OTHER KEY REPORTS / DECISIONS	Minutes of the Committee
LINKS TO OTHER RELEVANT FRAMEWORKS BAF, RISK, OUTCOMES ETC	Trust Board Assurance Framework NHS Audit Framework
IMPLICATIONS FOR SERVICE DELIVERY AND FINANCIAL IMPACT	Timely Reporting to the Board of Directors
CONSIDERATION OF LEGAL ISSUES	None Required

Author of Report	Mervyn Thomas
Designation	Chair, Quality Assurance Committee (Non-Executive Director)
Date of Report	January 2017

SUMMARY REPORT

Report to: Board of Directors
Date: 8th February 2017
Subject: Quality Assurance Committee – Summary Report to the Board of Directors in respect of Significant Issues
From: Mervyn Thomas, Chair, Quality Assurance Committee

1. Purpose

To report to the Board of Directors, items of significance discussed at the Quality Assurance Committee meeting held on 23rd January 2017.

2. Summary

Board members will receive the minutes of the Quality Assurance Committee held on 23rd January in February. However, the meeting is reviewed and the Committee agreed by means of this report to notify the Board of Directors of the following significant issues.

Coronial Report – Review of last 4 inpatient suicides

This report reviewed four suicides that had occurred at the Michael Carlisle Centre from 2011 to 2016. The findings identified that all four patients had complex psychosis based illnesses which are difficult to treat and manage. All of the patients were asked about their intentions and thoughts of self-harm and in all cases increased concerns over potential self-harm had led to increased levels of observation. The Committee discussed that patients who are most acutely unwell can be unpredictable and impulsive and were assured that the Trust has put in place a range of clinical, environmental and staff developments to take account of the increasing complexity and acuity in the acute inpatient pathway.

Serious Incident Report (Inpatient Suicide)

The Committee received and discussed the Trust's serious incident investigation report findings and action plan into a suicide using ligation on Stanage Ward in July 2016. The report findings identified no significant lapse in care that may have contributed to the death and the incident investigators concluded that the incident was unavoidable. The findings from this investigation had been included within the coronial report, mentioned above.

CQC Mental Health Act Reviews

This report provided information on a new governance system the Care Standards Team has introduced to provide assurances that actions required following CQC Mental Health Act Review visits is monitored and reported centrally on a monthly basis. The Committee was assured by the system established and was satisfied with the progress that had been made to remedy the issues raised by these reviews.

Corporate Risk Register

The Committee received the high levels risks recorded on the corporate risk register. It was noted during the discussion of this item that a risk that had previously been identified as warranting escalation to the corporate risk register, was omitted from the report due to an administrative error. Following a check of the risk management system, confirmation was received that the risk of ligation had been correctly escalated to the corporate risk register and that this would show on future reports.

3. Required Actions

For the Board of Directors to note the issues raised and receive assurance the Quality Assurance Committee take appropriate action.

4. Contact Details

Mervyn Thomas, Chair of Quality Assurance Committee