TRUST BOARD MEETING – 25 July 2013

Title of the Paper:	**Serious Incidents 2012 / 2013 – Summary Report**
Agenda item:	**Part 1** **Item 37/13**
Author:	**Dr Mike Van der Watt, Medical Director**
Trust Objective:	Achieve continuous improvement in the quality of patient care that we provide and the delivery of service performance across all sites.

Purpose

To provide a summary of the number of serious incidents reported during 2012 / 2013, the reporting trends observed and the themes emerging from incident investigation.

KEY HEADLINES TO NOTE:

1. The rise in reporting of serious incidents is attributed to the expanding criteria for serious incident reporting, the increasing level of awareness of what constitutes a serious incident across the organisation and the introduction of a format to encourage junior doctors to report incidents.
2. The majority of serious incidents are pressure ulcers – of the 46 reported, 18 were deemed avoidable and the remainder downgraded.
3. The Trust has commissioned an external review of governance structures and current arrangements, and will be appointing an interim Director of Quality and Patient Safety.

Risk Implications for the Trust (*including any clinical and financial consequences):*	**Mitigating Actions** *(Controls):*
Risk of not reporting, investigating and learning from serious incidents.	Serious Incident Policy and Procedures Findings reviewed at Serious Incident Review Group

Level of Assurance that can be given to the Trust Board from the report

Sufficient

Recommendation to the Trust Board

To note the report and identify issues for which further assurance is required.