

### TRUST BOARD MEETING – 24 November 2011

<b>Title of the Paper:</b>	Serious Incident Summary Report	
<b>Agenda item:</b>	177/11	
<b>Author:</b>	Dr Colin Johnston, Director of Patient Safety, Medical Director	
<b>Trust Objective:</b>	Provide safe patient care.	
<b>Purpose</b>  This report appraises the Board of the serious incidents reported since the previous Board meeting, the current status of open investigations and details of incidents closed since the last report.		
<b>Risk Implications for the Trust</b> ( <i>including any clinical and financial consequences</i> ):		<b>Mitigating Actions</b> ( <i>Controls</i> ):
Risks to patient safety if the Trust does not robustly investigate root causes, identify remedial actions required and ensure cross Trust learning to prevent recurrence of SIs.		Implementation of serious incident reporting processes and robust monitoring of progress in relation to investigation, learning, improving and closing incidents.
<b>Level of Assurance that can be given to the Trust Board from the report</b> Sufficient		
<b>Links to Board Assurance Framework, CQC Outcomes, Statutory Requirements (ie BAF risk reference, CQC outcomes linked to report)</b>  BAF		
<b>Legal Implications:</b>		
<b>Recommendation to the Trust Board:</b>  The Trust Board members are asked to:  <div style="margin-left: 40px;">Note the content of the report, details of the two most recent incidents and identify any areas for which further assurance is sought.</div>		