

TRUST BOARD MEETING – Thursday 29 September 2011

Title of the Paper:	Serious Incident Summary Report (Part 1)
Agenda item:	139/11
Author:	Colin Johnston, Medical Director / Director of Patient Safety
Trust Objective:	Provide Safe Patient Care
Purpose The summary report outlines current status in relation to the management of serious incidents currently open and proceeding through the investigation and learning process.	
Risk Implications for the Trust (<i>including any clinical and financial consequences</i>):	Mitigating Actions (<i>Controls</i>):
Failure to ensure Trust undertakes robust investigation and analysis of serious incidents will result in failure to take appropriate preventative action and ensure lessons are learned. This may threaten safe care.	<ul style="list-style-type: none">• Incident investigation is undertaken in a robust and timely manner.• Lessons identified and shared.• Remedial action taken.
Level of Assurance that can be given to the Trust Board from the report N/A	
Links to Key Line of Enquiry (KLOE 1 - 5) 4.1 NHSLA Standards, Quality Governance Requirements (inc CQC compliance)	
Recommendation to the Trust Board: The Trust Board members are asked to: <ul style="list-style-type: none">• Review and note the contents of the summary.	