West Hertfordshire Hospitals NHS
NHS Trust

TRUST BOARD MEETING – 29th November 2012

Title of the Paper:	Serious Incident Summary Report
Agenda item:	**Part 1** **Item 22/12**
Author:	Dr Colin Johnston, Director of Patient Safety, Medical Director
Trust Objective:	Provide safe patient care

Purpose

This report apprises 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.

Risk Implications for the Trust (*including any clinical and financial consequences):*	**Mitigating Actions** *(Controls):*
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.

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

Links to Board Assurance Framework, CQC Outcomes, Statutory Requirements (i.e. BAF risk reference, CQC outcomes linked to report)

BAF and NHSLA, CQC Outcome 16, 4, 8

Legal Implications:

Recommendation to the Trust Board:

The Trust Board members are asked to:

- note the content of the report, details of the 24 recent serious incidents declared and identify any areas for which further assurance is sought