West Hertfordshire Hospitals NHS
NHS Trust

Trust Board 28 November 2013

Title of the Paper:	Serious Incident Summary Report
Agenda item:	**TB Item 90/13**
Author:	Dr Mike Van der Watt, Medical Director
Trust Objective:	Achieving continuous improvement in the quality of patient care that we provide and the delivery of service performance across all areas

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.

Previously Discussed And Date For Further Review (list relevant committees)
Trust Leadership Executive Committee 7 November 2013

Benefits To Patients And Patient Safety Implications
This report provides information on the actions being taken when incidents are declared

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.

Links to Board Assurance Framework, CQC Outcomes, Statutory Requirements
BAF and NHSLA

Legal Implications: (if applicable)

Financial Implications :(if applicable)

Communications Plan (if applicable)

Recommendations

The Board is asked to:

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

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West Hertfordshire Hospitals NHS Trust

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Trust Board 28 November 2013

Serious Incident (SI) Summary Report

Presented by: Dr Mike Van der Watt

1. Purpose

1.1 The report sets out the serious incidents reported since the September 2013 report, the current status of open investigations and the number of incidents closed since the last report.

2. Summary Analysis

2.1 Since the September Board Report, 18 Serious Incident (SI) cases have been declared to the Clinical Commissioning Group (CCG) / Trust Development Authority (TDA)

2.2 54 SI cases are progressing through various stages of investigation. Of these:

- 6 are for 2012/2013 and 48 are for 2013/2014.
- 19 SI reports are currently due to the CCG/TDA, of which 4 are overdue.
- The CCG agreed that 3 HAPUs were unavoidable and no longer SIs.
- The CCG downgraded 4 SIs as they did not meet the SI criteria following investigation and are no longer SIs.
- 17 SIs were closed during September and October 2013 by the CCG.
- 23 SIs require the submission of evidence of action plan implementation once the actions are complete in order to be considered for closure by the CCG.

2.3 Appendix one presents summary information on the number of reported SIs from 1st April 2013 to 25th October 2013.

4. Recommendation

4.1 The Board is asked to note this report.

Dr Mike Van der Watt
Medical Director
25tOctober 2013

Appendix one

Table one: The profile of Trust Serious Incident reporting 2013/14

Incident Type	2013/2014						
	April	May	June	July	Aug	Sept	Oct
Clinical incident - Never Event	0	0	0	0	0	0	0
Clinical incident – Other	3	5	4	8	1	3	2
Non clinical incident	0	0	2	3	1	0	1
Information Governance	0	0	3	1	0	1	1
Hospital Acquired Grade 3 Pressure Ulcers	2	1	2	2	3	1	1
Safeguarding / Allegations of Abuse	0	0	3	3	1	1	0
Infection Control	2	1	2	9	1	0	0
Maternity	0	1	0	0	0	2	0
Falls / #NOFs	1	0	1	0	0	1	3
Total reported for Month	**8**	**8**	**17**	**26**	**7**	**9**	**8**
Running total year to date	**8**	**16**	**33**	**59**	**66**	**75**	**83**

Table two: The profile of Serious Incident reports by Directorate 2013/14

Directorate	2013/2014						
	April	May	June	July	Aug	Sept	Oct
Medicine	6	4	10	19	3	3	4
Surgery and Anaesthesia	1	3	2	5	2	3	2
Women's and Children's Services	1	1	2	0	1	3	1
Clinical Support Services	0	0	1	0	1	0	0
Infrastructure and Facilities	0	0	2	1	0	0	0
Corporate	0	0	0	1	0	0	1
Finance/Information Services	0	0	0	0	0	0	0