DATE	**22 December 2015**
REPORT FOR	**Trust Board of Directors – Public**
REPORT FROM	**Wendy Booth, Director of Performance Assurance & Trust Secretary**
CONTACT OFFICER	**Kelly Burcham, Head of Risk and Clinical Audit**
SUBJECT	**Serious Incidents including 'Never Events'**
BACKGROUND DOCUMENT (IF ANY)	**N/A**
REPORT PREVIOUSLY CONSIDERED BY & DATE(S)	**Trust Governance & Assurance Committee – 2 December 2015**
EXECUTIVE COMMENT (INCLUDING KEY ISSUES OF NOTE OR, WHERE RELEVANT, CONCERN AND / OR NED CHALLENGE THAT THE BOARD NEED TO BE MADE AWARE OF)	**The report provides the monthly anonymised summary of Serious Incidents (including 'Never Events') which have occurred since the date of the last Trust Board meeting**
HAVE THE STAFF SIDE BEEN CONSULTED ON THE PROPOSALS?	**N/A**
HAVE THE RELEVANT SERVICE USERS/CARERS BEEN CONSULTED ON THE PROPOSALS?	**N/A**
ARE THERE ANY FINANCIAL CONSEQUENCES ARISING FROM THE RECOMMENDATIONS?	**NO**
IF YES, HAVE THESE BEEN AGREED WITH THE RELEVANT BUDGET HOLDER AND DIRECTOR OF FINANCE, AND HAVE ANY FUNDING ISSUES BEEN RESOLVED?	**N/A**
ARE THERE ANY LEGAL IMPLICATIONS ARISING FROM THIS PAPER THAT THE BOARD NEED TO BE MADE AWARE OF?	**NO – the presentation of the data takes account of the requirements of the Data Protection Act**
WHERE RELEVANT, HAS PROPER CONSIDERATION BEEN GIVEN TO THE NHS CONSTITUTION IN ANY DECISIONS OR ACTIONS PROPOSED?	**YES**
WHERE RELEVANT, HAS PROPER CONSIDERATION BEEN GIVEN TO SUSTAINABILITY IMPLICATIONS (QUALITY & FINANCIAL) & CLIMATE CHANGE?	**N/A**
THE PROPOSAL OR ARRANGEMENTS OUTLINED IN THIS PAPER SUPPORT THE ACHIEVEMENT OF THE TRUST OBJECTIVE(S) AND COMPLIANCE WITH THE REGULATORY STANDARDS LISTED	**Ensures compliance with the Duty of Candour and is consistent with an open and transparent culture**
ACTION REQUIRED BY THE BOARD	**The Board is asked to note the report**

SERIOUS INCIDENTS (SIs) INCLUDING 'NEVER EVENTS' – December 2015

PURPOSE OF THE REPORT

This report provides:

- a high level, anonymised summary of the numbers and types of Serious Incidents including 'Never Events' reported since the date of the last Trust Board meeting in November 2015

In order to identify themes / trends, the report also provides:

- comparative data for the year to date

This approach is consistent with the routine publication (since December 2013) by NHS England of information on 'Never Events' and plans for the publication of information on Serious Incidents more generally and is consistent with a culture of openness and transparency.

The presentation of the data also takes account of the requirements of the Data Protection Act and the need to ensure patient confidentiality.

DEFINITIONS

Department of Health 'Never Events' Policy Framework September 2012:

'Never Events' are "serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers".

Note: On 27 March 2015, NHS England published its revised 'Never Events' Policy and Framework. There are now 14 types of incidents that are defined as a 'Never Event'. The purpose and definition of a 'Never Event' has been revised. This is to provide greater emphasis that a 'Never Event' arises from failure of strong systemic protective barriers. Under the revised arrangements although each 'Never Event' type has the potential to cause serious patient harm or death, harm is not required to have occurred for an incident to be categorised as a 'Never Event'.

NHS England 'National Framework for Reporting and Learning from Serious Incidents requiring Investigation' 2013:

Serious incidents requiring investigation in healthcare are rare, but when they do occur, everyone must make sure that there are systematic measures in place to respond to them. These measures must protect patients and ensure that robust investigations are carried out, which result in organisations learning from serious incidents to minimise the risk of the incident happening again. When an incident occurs it must be reported to all relevant bodies.

NLG Policy for Dealing with Serious Incidents (Clinical and Non-Clinical):

A **Serious Incident** is "an incident or series of incidents (in which one or more patients are involved) which are likely to produce significant legal, media or other interest or give rise to large scale public concern and which, if not properly managed, may result in significant loss of the Trust's reputation and/or assets".

KEY POINTS

In order to protect confidentiality of patients and staff, the report will be summarised and anonymised.

Further, where there is a need for discussion on a particular incident, this will occur in the Trust Board private session.

The Trust Governance & Assurance Committee will retain responsibility on behalf of the Trust Board, for monitoring the Trust's response to Serious Incidents including 'Never Events' and for providing assurance to the Trust Board that these incidents have been appropriately reported, investigated and that lessons have been learnt and remedial actions taken to minimise the risk of recurrence.

The Trust Governance & Assurance Committee (TGAC) received and considered the changes to the 'Never Events' Policy and Framework at its April 2015 meeting. A gap analysis is underway to determine the need for any further Trust actions to minimise the risk of occurrence of these types of events, this was presented as a first draft to the 18 May 2015 Trust Governance & Assurance meeting. A further report was provided to the July, September and October 2015 meeting. TGAC agreed that assurances for implementing the new framework had been received and that the report will be provided on quarterly basis going forward.

SUMMARY OF SERIOUS INCIDENTS:

	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4	TOTAL 2013 /14	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4	TOTAL 2014/15	15/16 Q1	15/16 Q2	15/16 Q3 (as at 9 December 2015)
12 Breach	1				1								
Avoidable Grade 3 / 4 Pressure Ulcer	10	5	2	11	28	4	18***	7	4	33	3		2
Communicable Disease				1	1						1		
Consent related incident							3			3			
Data Protection Act Issue				1	1		1			1			
Delay in Treatment	1	2			3						1		4
Delayed Assessment / Diagnosis		1			1	1	2	6	2	11		3	
Failure to Follow Up				1	1		1	1		2			
Flood		1			1								
HTA Reportable Incident					0	1	1			2			
IT Systems / Power Failure					0	1	1	1		3			
Missed Diagnosis	1				1								
Never Event - Wrong Implant*			11*		11*						1		
Never Event - Retained Foreign Object	1				1							1	
Never Event – Wrong Site Nerve Block											1		
Patient Misidentification	3	2	1		6								
Power Outage	1				1								
Resuscitation Issue			1		1								
Safeguarding Children				1	1								1
Safeguarding Adults					0	2		1	3	6	1	1	1
Screening Incident											1		
Treatment / Procedure Complication							1	2		3			
Unexpected Death**	1	4	3	1	9		2	3	2	7	1	1	
Intrapartum Event													1
Totals:	19	15	18	16	68	9	30	21	11	71	10	6	9

*   Same incident
**   Includes Intrapartum deaths and maternal deaths
*** 1 x SI was de-logged following initial investigations, where it was identified the pressure ulcer was ‘unavoidable’.

TRUST BOARD ACTION REQUIRED:

The Trust Board is asked to:

- note the report;
- consider and agree any additional actions required.