BOARD ASSURANCE FRAMEWORK & NEVER EVENTS

Debra Hickman Deputy Chief Nurse RWT

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Board Assurance Framework – what is it?

A Simple but comprehensive method for effective and focussed management of the principle risks that arise in meeting the Trust objectives.

Strategic objectives

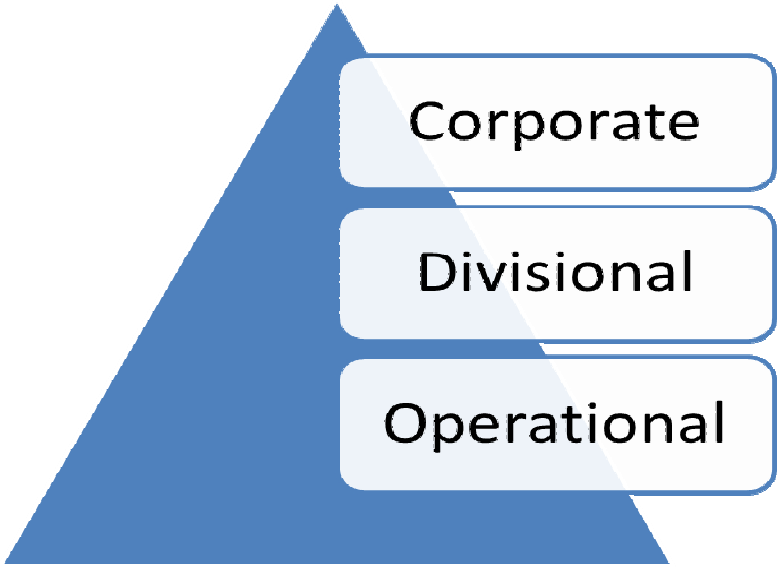
- Creating a culture of compassion, safety & quality
- Be in the top quartile for all performance indicators
- Proactively seek opportunities to develop our services
- To have an effective & well integrated organisation that operates efficiently
- Maintain financial health – appropriate investment enhancement to patient services
- Attract, retain & develop our staff & improve employee engagement.

Significant risks / threats

- Closure of a service
- Seriously prejudice / threaten achievement of a principle objective
- Threaten the safety of service users
- Threaten the reputation of the Trust and/or NHS
- Lead to significant financial imbalance and/or need additional funding to resolve and/or result in significant diversion of resources from another aspect of the business.

Process

- Operational risks are identified at local level and graded using a matrix system (consequence/likelihood).
- Smoke alarm.
- Reviewed bi monthly.
- Director led and Sub committee detailed review.



Never Events – what are they?

Introduced in 2009 by the National Patient Safety Agency -

Serious, largely preventable patient safety incidents that should not occur if National guidance / safety recommendations have been implemented.

Latest iteration of 2015 lists 14 Never Events.

National picture

Reported across England during June 2016 were:

- 8 Wrong site surgical interventions
- 7 retained foreign objects post invasive procedure
- 5 wrong implant / prosthesis
- 3 wrong route medication administrations
- 3 misplaced nasogastric/orogastric tubes
- 1 chest / neck entrapment due to bedrails
- 1 incompatible blood component transfusion

RWT picture

Year	Number
2010/11	2
2011/12	10
2012/13	3
2013/14	4
2014/15	5
2015/16	1

All Never Events have a detailed RCA

Actions following lessons learnt since 2010:

- Review of policies / processes.
- Training from Association for Peri-operative Practitioners
- Introduction of Human factors training via Simulation
- Introduction of Process Communication Model (PCM)
- Trust wide sharing of lessons learnt from incidents.
- Currently reviewing policies/procedures in line with National Safety standards for invasive