4.	**Incidents Review** JMc suggested that the layout of the report be changed so that the Level 1's and Level 2's are on the top of the report so they stand out rather than in the body of the report, also that one to one care has its own section within the tables so as not to be confused with COCH figures. **Quarterly trend analysis** Q1 trend analysis April - June total 357 incidents compared to 314 in the last quarter however, this may be due to Neonatal Hearing Screening Programme figures being added. Of the 357 incidents 323 were reported as clinical. **Audiology** 37 incidents relate to Newborn hearing screening – all incidents relate to delays in the issue of NHS numbers caused by incorrectly completing Meditech and some GP Surgeries not being on the National Spine. JCF has met with IM&T and discovered issue with Meditech system for bookings which is still ongoing. **Neonatal** 47 Incidents reported - 44 of which were clinical 2 moderate harm incidents relate to neonates that sadly died and the 5 top categories relate to 7 babies with feeding problems, 7 for delayed treatment, 6 Deviation from policy, 3 equipment problems and 3 unexpected deaths. **Paediatrics** 58 incidents – of which 46 were reported as clinical – no trends identified. 6 miscellaneous incidents, 3 Deviation from Policy, 2 patient preparation for theatre inadequate , 2 incorrect patient details and 2 delays in treatment. Trends identified as poor communication and poor demonstration. **Community Paediatrics** 3 incidents reported – all administration issues **Human Milk Bank** 12 incidents reported – 3 Donor Milk pasteurised, 2 Donor milk unpasteurised, 2 Health and Safety, 2 equipment malfunctions and 1 other equipment issue. **Gynaecology** 37 Incidents of which 35 were reported as clinical - 1 severe harm related to a patient who sustained damage to her one remaining fallopian tube and a moderate harm incident relates to a lost biopsy specimen from Colposcopy **Obstetrics** 162 incidents of which 155 were clinical - 18 relate to 3rd and 4th degree tears, 16 postnatal readmissions, 11 shoulder dystocia birth injury/admission to NNU, 10 Postpartum haemorrhage and 10 prescription errors plus 20 others not included in pick list. There was one Death incident relating to level 2 investigation and 3 moderate incidents relating to a baby being diagnosed with Erb's Palsy, a manual handling incident and the third relates to baby born by emergency caesarean section after day in obtaining paediatric review. Post mortem results are awaited **Summary - Trends identified across Women & Children's** The main issue appears to be with handover sheets and ward lists being misplaced with some of them appearing in patients hand held records or public places. It also includes letters containing the personal details of one patient being sent to another patient in error. Communication – including verbal and written communication