Policy for the Reporting and Management of Incidents Including Serious Incidents

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<tr>
<th>CATEGORY:</th>
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<tr>
<td>CLASSIFICATION:</td>
<td>Governance</td>
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<tr>
<td>PURPOSE</td>
<td>To set out the principles and framework for incident reporting, investigation, and learning from incidents including Serious Incidents</td>
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<td>Essential Reading for:</td>
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Appendices

- Appendix A: Monitoring Matrix
- Appendix B: Incident Examples
- Appendix C: Definitions
1. **Policy Statement**

1.1 The Trust is committed to minimising risks to patients, visitors and staff, as far as is reasonably practicable. Accurate and appropriate reporting and investigation of incidents including near misses is an essential part of reducing risks and improving patient safety. It is a requirement of all staff to report incidents that could have given rise to harm.

1.2 Avoiding serious incidents is a high priority; minimising and reducing the risks from hazards is good practice, meets legal requirements, and offers sound financial benefits. Therefore the Trust requires all employees to comply with the Policy for the Management of Incidents including Serious Incidents ("the Policy") and any associated procedures. See section 7 for a list of associated procedures.

2. **Scope**

2.1 This Policy applies to all individuals employed by the Trust including contractors, volunteers, students, locum and agency staff and staff employed on honorary contracts.

2.2 It applies to all incident types, including near misses, encompassing patient clinical, health and safety, facilities, security (including information security), information governance, radiation and violence, abuse and harassment.

2.3 For definitions of terms referred to in this Policy, please see Appendix C.

2.4 If staff wish to raise concerns about the Trust they should refer to the Trust Policy and Procedure for Raising Concerns in the Public Interest (Whistle Blowing). These documents identify the process for raising concerns and can be found on the Trust Intranet site for guidance. For further advice in these circumstances contact the Human Resources Department.

3. **Framework**

3.1 This section describes the broad framework for the reporting, management and investigation of incidents including Serious Incidents (SI). Operational instructions for risk management, investigation of incidents, and learning from incidents are detailed in separate procedural documents which are approved by the Director of Corporate Affairs.

3.2 **Immediate Action Following an Incident**
3.2.1 When an incident occurs:
   a) if there is a remaining risk, all practical and reasonable steps must be taken to prevent re-occurrence and ensure the area is safe and
   b) the appropriate senior clinicians/managers must be informed, as soon as possible; and

3.2.2 Where death or serious injury has occurred an incident report form must be completed within 48 hours and the clinical risk and compliance team notified at the earliest opportunity.

3.3 Incident Reporting

The Trust requires all clinical and non-clinical incidents, including near misses, to be formally reported (See Appendix B for examples of incidents). When an incident occurs a Trust Incident Report Form (IRF) must be completed as soon as possible, in line with the Procedure for the Reporting and Management of Incidents Including Serious Incidents.

3.4 Review and Investigating Incidents

3.4.1 Within 7 days of the incident being reported the person who has been identified as the ‘Incident Handler’ in Datix (see definitions) is to review the incident and advise on what actions have been taken and feed this back to the person who reported the incident.

3.4.2 The Risk and Compliance Unit are to review all incidents reported the following working day to:
   a) Categorise the incident according to the incident details; and
   b) determine if the incident requires further investigation in accordance with the relevant procedures as outlined in section 7.

3.5 Being Open and Duty of Candour

3.5.1 The Trust is aware of its Duty of Candour and is committed to ‘being open’. Promoting a culture of openness is a prerequisite to improving patient safety and the quality of healthcare systems. It involves acknowledging and explaining what happened to patients where harm has resulted and apologising where required. It encompasses communication between healthcare
organisations, healthcare teams and patients, their families, and carers.

3.5.2 All incidents of moderate, severe harm or death are managed according to the Being Open and Duty of Candour Policy and Procedure.

3.6 Supporting Staff

3.6.1 The line manager is responsible for the provision of initial support for staff involved in an incident.

3.6.2 This could be in the form of 1:1 discussion, debrief session or referral to Staff Support.

3.6.3 Staff Support Services offer one-to-one counselling and long-term support. This service is independent of the management structure and is completely confidential.

3.7 Reporting to External Agencies

Where an incident is required to be reported to an external agency this will be done in accordance with the relevant procedures as outlined in section 7.

3.8 Incidents Involving other Organisations

3.8.1 Where an incident is linked to care or services where elements of that care or service are shared with other organisations, the Risk and Compliance Unit must contact the other organisation with details of the incident.

3.8.2 Conversely, if another organisation notifies any member of staff of an incident in their organisation involving elements of care or service at the Trust, the Risk and Compliance Unit must be notified and the incident reported and managed through Datix in accordance with this policy.

3.8.3 When the care provided is shared between organisations, it may be appropriate to arrange a joint investigation of the incident, particularly if there has been joint involvement in an SI and escalation to the commissioners. It can also be of benefit to jointly review other cases of shared care, for example those relating to patients with rare conditions, or cases that result in a serious outcome for the patient, but which do not fall into an SI category; to provide an opportunity for learning lessons and improving cross organisation pathways.
3.8.4 In such instances, the Risk and Compliance Unit, in discussion with the Medical Director/Executive Chief Nurse, will liaise with the relevant organisation to:

a) agree which organisation will lead the investigation/review

b) ensure the appropriate stakeholders from each organisation are invited to contribute towards and attend the investigation/review meeting

c) ensure each organisation has had input into the report and receives a copy of the final report and associated action plan

d) monitor implementation of action plan.

3.9 Learning from Incidents/Risk Reduction

3.9.1 It is important that there is learning from incidents and, where appropriate, that this learning is disseminated across the Trust. The associated procedural documents provide further detail in relation to learning from incidents and aggregated reporting of complaints, incidents and claims.

3.9.2 Where relevant, risks highlighted via the Incident Reporting System (Datix) and from investigations will be added to the appropriate Risk Register in accordance with the Procedure for the Assessment of Risks and Management of Risk Registers.

3.10 Training

The Trust will ensure that the appropriate training is provided to all relevant staff as set out in the Training Needs Analysis document.

4. Duties

4.1 Chief Executive

The Chief Executive is the accountable officer with overall responsibility for risk management. As such, the Chief Executive must take assurance from the systems and processes for risk management and ensure these meet statutory requirements and the requirements of regulators.

4.2 Director of Corporate Affairs

The Director of Corporate Affairs is responsible for:
a) Overseeing compliance with the Policy and providing assurance to the Board of Directors on compliance with this Policy; and

b) Approving all related procedures.

4.3 **Executive Directors**

4.3.1 The Executive Directors are responsible for:

a) Ensuring that all staff adhere to the Trust reporting procedures; and

b) Ensuring that appropriate preventative action has been taken in all cases.

4.3.2 The Chief Nurse and Medical Director have specific responsibility for:

a) Approving the level of investigation required for an incident (via the Clinical and Professional Review of Incidents Group);

b) Approving the reporting of SIs to the relevant external agencies as appropriate; and

c) Approving the investigation outcomes relating to their area of executive responsibility.

4.4 **Director for Infection Prevention and Control**

The Director for Infection Prevention and Control must ensure the Consultant in Communicable Disease Control (CCDC) and the Health Protection Agency (HPA) are informed of any reportable infection control incidents.

4.5 **Serious Incident Review Group**

Members of the Group are responsible for:

a) Facilitating discussion with Divisional teams regarding report recommendations;

b) agreeing the proposed action plans from report recommendations with Divisional teams

c) providing a quality assurance of all investigation reports prior to Executive Director approval
4.6 Chief Pharmacist

The Chief Pharmacist is responsible for ensuring:

a) A review of all ‘medication incidents’ in Datix is undertaken on a monthly basis;

b) relevant actions are put in place following the reporting of medication incidents; and

c) appropriate incidents are reported to the MHRA.

4.7 Divisional Management Teams

The Divisional Management Teams are responsible for:

a) Ensuring that incidents which may require further investigation in line with the Procedure for the Reporting and Management of Incidents Including Serious Incidents are reported via a Trust incident report form. assisting in the identification of the staff involved in a Serious Incident;

b) ensuring that the identified staff involved in an investigation cooperate with the investigation team and where required, submit a statement and are available to attend any appropriate incident interview or roundtable;

c) supporting the initial investigation case assessment/ to identify the level of investigation required;

d) ensuring that the principles of ‘Being Open’ are adhered to and where required all aspects of the duty of candour requirements are adhered to (this may include attending meetings with the patient and or relatives to feedback the outcome of an investigation);

e) attending the Serious Incident Review Group to review the draft investigation report with the group members and Investigation Officer and to agree the action plan in response to any recommendations; and
f) ensuring that the agreed action plan is implemented and provide the Risk and Compliance department with assurance of the implementation of actions.

4.8 **Senior Manager Information Governance**

The Senior Manager Information Governance must ensure:

a) Relevant actions are taken following the reporting of information governance incidents; and

b) information governance and security incidents are investigated and reported in line with the guidance issued by the Health and Social Care Information Centre (HSCIC) for dealing with information incidents.

4.9 **Risk and Compliance Unit**

4.9.1 Members of the Risk and Compliance Unit must:

a) Undertake quality checks on all reported incidents through the Datix system.

b) Identify incidents which may require further investigation in line with the Procedure for the Reporting and Management of Incidents Including Serious Incidents; and

c) analyse incidents and associated investigations to identify trends and report these to the appreciate Group within the Trust.

4.9.2 Manage the investigation process by:

a) Reporting to external agencies as appropriate;

b) ensuring the Divisional Management Teams develop action plans following a SI and ISI investigation and monitor completion of the actions through the action plan module in Datix;

c) overseeing and facilitating compliance with Being Open and Duty of Candour Policy and Procedure;
d) assisting with the population of Serious Incident CEAG reports;

e) assisting with the population of feedback letter and meetings to patients/families to complete the Duty of Candour Process; and

f) Monitoring compliance with the Policy.

4.10 **Health and Safety Team**

Members of the Health and Safety Team must:

a) Monitor health and safety incidents and the recording of recommendations advice to handler using the Trust incident reporting database (Datix);

b) analyse Trust incident data to identify Trust trends;

c) provide quarterly incident reports to the Trust Health, Safety and Environment Committee and its sub committees;

d) identify health and safety incidents which require further investigation;

e) provide expert support and assistance to the investigation of health and safety incidents;

f) provide expert advice to management on appropriate action following an incident;

g) analyse incidents, associated investigations and appropriate follow ups within individual departments as part of the health and safety audit programme; and

h) having received approval from the Director of Corporate Affairs, complete external reports as appropriate e.g. to the Health and Safety Executive (HSE), insurers and lawyers. This includes incidents that are reportable under the 'Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995' (RIDDOR).

4.11 **Radiation Protection Advisor**

The Radiation Protection Advisor must:
a) Advise on the radiological impact of incidents with respect to dose and risk; and

b) advise the departmental/service manager whether the incident needs to be reported to an external organisation. (The Manager will then ensure that the Group Manager, Divisional Director of Operations, and Chief Operating Officer are aware of any notification about to take place).

4.12 Medical Engineering Manager

The Medical Engineering Manager must:

a) Report to the Medicines and Healthcare Products Regulator Authority (MHRA) any incidents related to a medical device or piece of equipment, including disposables, which fails and which compromises patient care;

b) ensure that failed Medical Devices are examined and impounded if necessary; and

c) ensure any follow up actions from reported medical device incidents are documented on the incident reporting database.

4.13 Local Security Management Specialist

The Local Security Management Specialist must ensure:

a) Relevant actions are taken following the reporting of security incidents; and

b) appropriate violence and abuse and security incidents are reported to the Security Management Services.

4.14 Incident Handlers

Incident Handlers are responsible for:

a) ensuring all incidents are reported by their staff as soon as reasonably practicable in compliance with the Procedure for the Reporting and Management of Incidents Including Serious Incidents;
b) reviewing all incidents reported for their area and completing the handler section (including feedback to staff) of the incident report form within 7 days of the incident being reported;

c) providing feedback to the individual who reported the incident on any relevant action taken;

d) if appropriate, informing the relevant Departmental Manager, Matron or Divisional Management Team;

e) adhering to the Being Open and Duty of Candour Policy and Procedure;

f) taking action to prevent recurrence where required and documenting this on the incident report form; and

g) supporting staff in accordance with Section 3.6.

4.15 Designated Individual for the Post Mortem Licence Issued by the Human Tissue Authority

The Designated Individual for the Post Mortem Licence issued by the Human Tissue Authority must:

a) Ensure all incidents related to storage and release of bodies, and organs and tissue removed from body post mortem are reported and investigated;

b) ensure SI incidents are reported to the Human Tissue Authority; and

c) ensure relevant actions are put in place following the investigation of incidents related to storage and release of bodies, and organs and tissue removed from body post mortem.

4.16 All Staff

All staff must:

a) Comply with the Policy and all related procedures;

b) take all practical and reasonable steps to prevent re-occurrence of the incident and ensure the area is safe

c) report incidents in accordance with the Procedure for the Reporting and Management of Incidents Including Serious Incidents;
d) where applicable, cooperate with any incident investigation and provide any information requested in a timely manner; and

e) attend any risk training deemed necessary for their role.

5. Implementation and Monitoring

5.1 The Policy and the associated procedural documents will be available on the Trust intranet.

5.2 Education will be made available as outlined within the associated procedural documents.

5.3 Appendix A provides full details on how the policy will be monitored by the Trust.

5.4 The associated procedural documents provide further details of implementation and monitoring.

5.5 The Trust reserves the right to change the reporting and monitoring processes as required.

6. References

Building a Safer NHS for Patients, Department of Health (2001)

HSCIC

Organisation with a memory, Department of Health (2000)

National Framework for Reporting and Learning from Serious Incidents Requiring Investigation NPSA (2010)


7. Associated Policy and Procedural Documentation

Being Open and Duty of Candour Policy

Being Open and Duty of Candour Procedure

Claims Handling Policy

Claims Handling Procedure

Complaints Policy
Complaints Procedure

Information Governance Policy

Inoculation Injury Management Procedure

IG Incident Procedure

IT Security Procedure

Manual Handling Procedure

Policy for the Management of Medical Devices

Policy for the Prevention, Reduction and Management of Slips, Trips and Falls Including Work at Height

Policy and Procedure for Raising Concerns in the Public Interest (Whistle blowing)

Procedure for the Prevention of Slips Trips and Falls

Procedure for the Reporting and Management of Incidents including Serious Incidents

Radiation Safety Policy

Risk Management Strategy and Policy

Training Needs Analysis
## Appendix A  

### Monitoring Matrix

<table>
<thead>
<tr>
<th>Monitoring of Compliance</th>
<th>Monitoring Lead</th>
<th>Reported To Person/Group</th>
<th>Monitoring Process</th>
<th>Monitoring Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality assuring the incident coding of reported incidents</td>
<td>Datix Manager</td>
<td>Clinical Risk Manager</td>
<td>An audit of a sample of incidents to review the quality of clinical coding and make amendments as necessary.</td>
<td>Weekly</td>
</tr>
<tr>
<td>Review of the process of investigating incidents</td>
<td>Risk and Compliance Unit</td>
<td>Serious Incident Review Group</td>
<td>Quality assurance of serious incidents and internal serious incidents</td>
<td>At each meeting</td>
</tr>
<tr>
<td>Monitor implementation of action plans to ensure local learning</td>
<td>Risk and Compliance Unit</td>
<td>Divisional Clinical Quality Groups, Patient Safety Group</td>
<td>An audit of a sample of action plans following an investigation to ensure actions have been implemented supplemented by supporting evidence</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Aggregated report of incidents, complaints, claims and PALS</td>
<td>Risk and Compliance Unit</td>
<td>Board of Directors</td>
<td>To ensure that the correct frequency has been achieved, the minimum requirements have been included (including qualitative and quantitative analysis) and the communication of the information has occurred, as required.</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Monitoring of Compliance</td>
<td>Monitoring Lead</td>
<td>Reported To Person/Group</td>
<td>Monitoring Process</td>
<td>Monitoring Frequency</td>
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</tr>
<tr>
<td>CQMG receives a Risk Management report which includes reported incident trends and progress with Serious Incidents</td>
<td>Medical Director</td>
<td>Clinical Quality Monitoring Group</td>
<td>Where there is evidence of significant changes in incident trends assurance may be sought from the relevant department.</td>
<td>Monthly</td>
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### Appendix B  Examples of Incidents

This is not an exhaustive list and staff should report all events which they feel meet the definition of an incident (Appendix C).

<table>
<thead>
<tr>
<th><strong>Clinical Incident</strong> (may or may not directly affect a patient)</th>
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<tbody>
<tr>
<td>Administration Error</td>
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<tr>
<td>Bed Management Issue</td>
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<tr>
<td>Blood Transfusion Issue</td>
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<tr>
<td>Communication Failure</td>
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<tr>
<td>Cancellation/Delay of patient care</td>
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<tr>
<td>Discharge/Transfer Issue</td>
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<tr>
<td>Ionising/Non-ionising radiation Issue</td>
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<tr>
<td>Medical or Non Medical Equipment fault, user error or lack of</td>
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<tr>
<td>Medication Error</td>
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<tr>
<td>Medical Records Issue</td>
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<tr>
<td>Patient Fall</td>
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<tr>
<td>Specimen sample Issue</td>
</tr>
<tr>
<td>Staffing Issue</td>
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<tr>
<td>Test Results Issue</td>
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<td>Theatre Issue</td>
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<tr>
<th><strong>Health and Safety Incident</strong></th>
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<tr>
<td>Biological or Chemical Exposure</td>
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<tr>
<td>Cut with sharp material</td>
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<tr>
<td>Fall</td>
</tr>
<tr>
<td>Inoculation incident</td>
</tr>
<tr>
<td>Manual handling Issue</td>
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<tr>
<td>Road Traffic Accident</td>
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<tr>
<th><strong>Facilities Incident</strong></th>
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<tr>
<td>Building Issues</td>
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<td>Catering Issues</td>
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<td>Fire Incident</td>
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<tr>
<td>Environmental Issues</td>
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<tr>
<td>Grounds and Gardens Issues</td>
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<tr>
<td>Transport Issues</td>
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<tr>
<td>Waste Issues</td>
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<tr>
<td>Issues with essential services, eg, electric, gas, water</td>
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<tr>
<th><strong>Security Incident</strong></th>
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<tr>
<td>The theft of any Staff, Patient, Trust or Visitor Property</td>
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<tr>
<td>Burglary of any office or premises, whether items are stolen or not</td>
</tr>
<tr>
<td>Criminal Damage to any property, equipment or item.</td>
</tr>
<tr>
<td>Loss of personal information of staff and/or patients</td>
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<tr>
<td>Vehicle Crime</td>
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<tr>
<td>Vandalism</td>
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<tr>
<th><strong>Violence, Abuse and Harassment</strong></th>
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<tr>
<td>A member of staff, a patient or a visitor is verbally abused or harassed.</td>
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<tr>
<td>Inappropriate conduct of staff, a patient or a visitor.</td>
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</table>
A member of staff, a patient or a visitor is physically abused.
Appendix C

Definitions

Assault
The intentional application of force against the person of another without lawful justification, resulting in physical injury or personal discomfort.

Death
Any patient safety incident that directly resulted in the death of one or more patients.

Incident
An unplanned or unexpected event that may or may not lead to injury, damage or loss to an individual or the Trust.

Incident Handler
The individual who is assigned as the line manager for the reported incident with the Datix incident reporting system.

Low harm (Minor)
Any patient safety incident that required extra observations or minor treatment and caused minimal harm to one or more patients.

Moderate harm
Any patient safety incident that resulted in moderate increase in treatment and that caused significant but not permanent harm.

Near Miss (prevented)
Any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to the patients.

No Harm
Any patient safety incident that caused no harm but was not prevented.

Patient Safety Incident
Any unintended or unexpected incident(s) that could have or did lead to harm for one or more persons receiving NHS-funded healthcare.

Severe harm
Any patient safety incident that appears to have resulted in permanent harm to one or more patients.
Serious Incidents in the NHS include:

- Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:
  - Unexpected or avoidable death of one or more people. This includes:
    - suicide/self-inflicted death; and
    - homicide by a person in receipt of mental health care within the recent past;
  - Unexpected or avoidable injury to one or more people that has resulted in serious harm;
  - Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:
    - the death of the service user; or
    - serious harm;

- Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:
  - healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or
  - where abuse occurred during the provision of NHS-funded care.

This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident.

- A Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death. See Never Events Policy and Framework for the national definition and further information;

- An incident (or series of incidents) that prevents, or threatens to prevent, an organisation’s ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:
• Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues;
• Property damage;
• Security breach/concern;
• Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population;
• Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS);
• Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services); or
• Activation of Major Incident Plan (by provider, commissioner or relevant agency)
• Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation.