

shared as appropriate. Where this is not happening – for example where serious incidents are not being reported to commissioners or regulators within the required timescales once organisations are aware of them (or event not reported at all) or where investigations and action plans are not effective and robust, it is appropriate to undertake regulatory action or performance management of the organisation. Information about serious incidents should also be triangulated with other information and intelligence; for example, that obtained through Quality Surveillance Groups.⁶

Part One: Definitions and Thresholds

1. What is a Serious Incident?

In broad terms, serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare.

The occurrence of a serious incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm⁷ to patients or staff, future incidents of abuse to patients or staff, or future significant reputational damage to the organisations involved. Serious incidents therefore require investigation in order to identify the factors that contributed towards the incident occurring and the fundamental issues (or root causes) that underpinned these. Serious incidents can be isolated, single events or multiple linked or unlinked events signalling systemic failures within a commissioning or health system.

There is no definitive list of events/incidents that constitute a serious incident and lists should not be created locally as this can lead to inconsistent or inappropriate management of incidents. Where lists are created there is a tendency to not appropriately investigate things that are not on the list even when they should be investigated, and equally a tendency to undertake full investigations of incidents where that may not be warranted simply because they seem to fit a description of an incident on a list.

The definition below sets out circumstances in which a serious incident must be declared. Every incident must be considered on a case-by-case basis using the description below. Inevitably, there will be borderline cases that rely on the judgement of the people involved (see section 1.1).

⁶ Guidance on running Quality Surveillance Groups can be found at: <http://www.england.nhs.uk/wp-content/uploads/2014/03/quality-surv-grp-effective.pdf>

⁷ Serious harm:

- Severe harm (patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care);
- Chronic pain (continuous, long-term pain of more than 12 weeks or after the time that healing would have been thought to have occurred in pain after trauma or surgery); or
- Psychological harm, impairment to sensory, motor or intellectual function or impairment to normal working or personal life which is not likely to be temporary (i.e. has lasted, or is likely to last for a continuous period of at least 28 days).