TOWER HAMLETS GP CARE GROUP (THGPCG) CIC
POLICY FOR INCIDENT MANAGEMENT AND REPORTING INCLUDING SERIOUS INCIDENTS

Date Issued	01/03/2018
Title	Policy for Incident Management and Reporting including Serious Incidents
Supersedes	All previous Policies
This policy will impact on	All staff
Related Documents	
Policy Area	Quality & Safety
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Author	Director of Quality & Assurance
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Reviewed by	Governance Committee	April 2018
Approved by	Chris Banks, CEO	May 2018 4/6/2018

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Introduction
Incident reporting is a fundamental tool of risk management and contributes to the development of a safety culture. The aim of incident reporting, investigation and management is to collect information about adverse incidents, including near misses, ill health and hazards, which will help to facilitate wider organisational learning. If incidents are not properly managed, they may result in a loss of public confidence in the organisation and a loss of assets, in addition to repeated occurrence.

The THGPCG directors support open and transparent systems of patient and staff safety and believe it is unacceptable to prioritise other objectives at the expense of patient safety.

The purpose of this document is to describe how THGPCG intends to ensure that all Serious Incidents are investigated appropriately and learning is shared in accordance with the National Framework for Serious Incidents https://improvement.nhs.uk/uploads/documents/serious-incidnt-framwrk.pdf

Scope
This policy applies to:

- Staff of any grades and role, in the THGPCG.
- Incidents that occur on any of the premises, including those that involve service users, employees, visitors or contractors.
- Incidents involving employees or service users that occur in any other setting, when an employee is carrying out his/her duties.
- Incidents that occur as a result of the care and treatment provided by service areas
- Serious Incidents (SI) such as a serious injury or a suspected suicide or homicide while a service user is receiving care and treatment from the service areas or has been in contact with services in the previous 6 months.
- Incidents that have actually occurred and those that were a 'near miss' where the potential for harm was significant.

Roles & Responsibilities

The **Accountable Officer** is ultimately responsible for ensuring compliance with the Health & Safety at Work Act 1974, associated legislation and Department of Health requirements. Therefore the Chief Executive Officer must ensure that this policy is implemented and effective within THGPCG.

The **SI Review Panel** is a sub-committee of the Clinical Quality & Governance Committee. The purpose of the panel is to ensure that THGPCG adheres to the NHS England's Serious Incident and Never Events Framework and fulfils their responsibility to the management of serious incidents

involving patients of the THGPCG services. The terms of reference for this panel are attached as appendix one.

The **Director of Quality and Assurance** (DoQ&A) has Board level responsibility for the monitoring and quality assurance of all incidents reported to THGPCG. The DoQ&A will receive reports from services on incidents and monitor follow up reports ensuring robust investigations have taken place and take responsibility for closing reports. The DoQ&A is responsible for ensuring the implementation of this policy and monitoring its effectiveness. They will ensure that the policy is adhered to including the internal and external reporting arrangements. They will ensure the designated email inbox for Datix is managed appropriately. They will provide reports on SIs for relevant committees and quality meetings. The DoQ&A is responsible for working with service leads to identify learning and implement a blended approach to sharing learning across teams.

The **THGPCG Executive Team** is responsible for reviewing the Root Cause Analysis (RCA) investigation reports produced for SIs declared by THGPCG. These reports will be produced by a designated lead investigator and sent to TH CCG by the DoQ&A within the agreed timescales for submission to the Strategic Executive Information System (STEIS) database for serious incidents.

The **Senior Manager on-call** has responsibility to assess the urgency of matters relating to incidents reported out of hours and to co-ordinate an appropriate response; this may link with procedures for emergency planning.

The **Governance Support Officer** for THGPCG is designated responsibility for monitoring the Datix email inbox (thgpcg.datix@nhs.net) and STEIS and forwarding the reports to the SI Review Panel. They will maintain a log of all SIs reported and update accordingly. They will provide reports on SIs for relevant committees and quality meetings.

Service Managers are responsible for ensuring that staff are aware of this and other related policies and procedures and how to access them for reference. They are also responsible for ensuring that staff access appropriate training and support for completing the Datix reports in a timely manner. The Service Manager will undertake the initial review and management of incidents assigned to them on the Datix system. They will grade the severity of the incident using the risk grading matrix to ensure the incident is responded to appropriately. Service Managers are responsible for ensuring that incident reporting processes within their service are effective and support robust safety, learning, just and open cultures. They will work with other Service Managers when necessary to address areas where a shared risk or learning action has been identified.

All Staff who suspect an incident has occurred should take immediate action to minimise and prevent further harm. All staff are responsible for ensuring that they have access via a personal log-in to the Datix system. Ensure you are familiar with this and other related policies and procedures. Report all incidents immediately to the Service Managers Manager/Deputy Manager. Volunteers, students, work experience placement etc. should report incidents to their supervisor, who is responsible for ensuring a Datix report form is completed in conjunction with the individual concerned.

Incident management

The first priority when an incident has occurred is to ensure the immediate safety and welfare of all those

involved or affected, directly and indirectly, and to take any necessary actions to prevent harm or further harm.

First Steps

The immediate responsibility for managing an incident falls to the most senior person on duty at the time the incident occurs, or is reported for the first time. The person managing or coordinating the response to the incident will ensure that all necessary actions are taken to make the situation safe, which may include:

- Support and information was/is offered to those affected directly or indirectly by an incident – service users, carers, visitors, staff or others.
- Liaise with the Named lead for Safeguarding Children where there is any concern about the welfare of a child (refer to the THGPCG Safeguarding Policy for contact details)
- Follow the THGPCG Safeguarding Vulnerable Adults Policy where the incident involves any allegation or suspicion of abuse of an adult in our care
- All incidents are reported on the same or next working day via the Datix system. Datix will enable escalation as appropriate once the form has been completed.
- Witness statements are taken as required.
- All incidents and accidents are correctly recorded on Emis Web (where appropriate) in a timely manner
- That paper records relating to incidents are transferred and stored safely and in accordance with the THGPCG Information Governance Policy and other related policies.
- Liaise with the HR Manager regarding any member of staff who is unable to perform their normal job for more than three days as a result of an accident or incident at work.
- Liaise with DoQ&A or deputy where there is a loss/ breach of person identifiable information
- Liaise with Human Resources where there are any concerns about staff capability, competence or behavior.
- Alerting Senior Manager on Call to any Serious Incident (refer to appendix 2 for definitions)
- Contacting and liaising with the Police if necessary

Next steps

When immediate actions necessary to manage the incident safely have been completed, there may be further actions required to ensure that the incident is effectively managed:

- Consider who needs to be informed and ensure that more people are aware of the incident as necessary

- Contact/liaise with the police as necessary
- Ensure that all potential evidence is retained intact and in safe-keeping for inspection. This may include clothing, equipment, messages and documents.
- Ensure that any potentially faulty equipment is withdrawn from use. Wherever possible it should be removed and/or locked away. If this isn't immediately possible it should be clearly labelled as unsafe and not for use
- Consider what further review, support and follow-up service users who were involved may need
- Consider what further review, support and follow-up staff may need e.g. staff going off duty may need support, advice or help
- Consider what information and support staff coming on duty may need – including staff returning to work from holiday or sickness absence
- It is not THGPCG policy to create paper healthcare records, however where these exist due to legacy arrangements these should be secured in the case of Serious Incidents. Secured means removed from use and placed in a secure place where they cannot be tampered with or amended.

These responsibilities may be addressed by the person managing the incident, or passed to the Service Manager. When these have been addressed the incident should be updated on using the Datix system, completing the investigation section as appropriate.

Low/No Harm Incidents

Incident Occurs	**Who**	**What**	**When**
Datix Completed & Submitted	Any member of staff	Report the incident, factual details, not opinions	**As soon as possible** after the incident, but within 12 hours
Local Sign off (Level 1 / 2) Management Action	Service Manager	Complete the local investigation inc level of harm, management action taken including where the patient is now, Duty of Candour if necessary	Local investigation should be completed **within 7 working days** as final sign off must be completed within 10 days
Final signed off	DoQ&A or COO	Ensure there is evidence to support the closure of the incident, learning identified & no	Incident should be finally closed **within 10 days** of the incident occurring unless SI or Higher

	further action required	level of investigation

Serious Incidents (SI)

Decision to declare an SI
The decision to declare an SI will be based on the definitions and thresholds in the NHS England's Serious Incident Framework (https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf). A summary of these definitions is available in appendix four.

Reporting an SI
All incidents considered to meet the criteria of a Serious Incident must be reported to the Quality Manager at TH CCG **within 2 working days** of when the incident was recognized for reporting to the Strategic Executive Information System (STEIS). The decision to declare an incident as an SI will be made by the DoQ&A or COO in conjunction with the service manager and the report made to the CCG following this decision by a member of this group. The DoQ&A or COO will also be responsible for adding the incident to the service risk register. The threshold used to In the circumstances where neither the DoQ&A or COO are available the CEO will appoint a suitable deputy.
Any SI resulting in bodily injury must be reported to the THGPCG insurers.

The SI Investigation
The DoQ&A or COO will be responsible for commissioning the investigation. The investigator/s must not be employed in the service in which the incident has occurred. The Lead Investigator will be accountable to the CEO and will have the following key skills and competencies

- Skills/ competencies in effective report writing and document formulation;
- Expertise in facilitating patient/family involvement
- Understanding of the specialty involved – this often requires representation from more than one professional group to ensure investigation balance and credible;
- Responsibility for administration and documentation (or for there to be adequate administrative and IT support);
- Knowledge/ expertise in media management and a clear communication strategy – or access to this specialist support via the organisation's communications team (see Appendix 7);
- Access to appropriate legal and/or information governance support where appropriate;
- Access to competent proof-reading services where required; and
- Appropriate links/mechanisms to share lesson locally and nationally during the investigation as required.

Where deemed appropriate this person will be from with the THGPCG, where it is not possible to appoint a suitable individual the QoQ&A will liaise with Tower Hamlets Together (THT) partners to appoint an individual from within the partnership. This decision will be taken using the NHS England Serious Incident Framework guidance. The Lead Investigator will comply with the THGPCG Duty Of Candour Policy requirements and ensure that patients and their families are put at the centre of the process.

A process map (refer to appendix two) details the SI investigation process

Multi-Agency Sis

Where the initial investigation identifies the involvement of one or more external agencies the Lead Investigator will liaise with the Clinical Governance Leads for the organisations involved. A meeting of the Governance Leads will agree on a Lead for the investigation. Where this is not possible the Lead Investigator will refer back to the DoQ&A for further guidance. If the external agencies involved are within the THT partnership a report will be sent the THT Quality & Safety Committee for a decision regarding the Lead organization.

De-escalating or closing an SI

All SI investigation reports will go through internal review **(40-45 days)** and must be completed) **within 60 days**. Where it is not possible to complete the investigation within this timeframe due to complexity or the involvement of other investigating bodies (eg Police) an extension should be sought with the Quality Manager and a reasonable deadline agreed.

Serious Incident reports will be sent to the TH CCG **within 60 working days**. These reports will be provided to the Police or the Coroner upon request where necessary.

On receipt of investigation reports, CCG will review and provide feedback to the THGPCG **within 20 days**. Once the report is closed by the CCG, this can be closed on Datix and shared with the family

Following conclusion of the investigation it may be decided that the threshold for an SI have not been met. This should be reported to the TH CCG Quality Manager who will complete the STEIS report to indicate this conclusion.

Documentation

Documentation regarding the SI will be retained in the Governance folder of the Tower R Drive. This documentation will be retained for 30 years.

Communication following incident

Communication with staff is key throughout the process and needs to take place both pre and post investigation. The manager is responsible for ensuring staff get support. When investigations take place staff have the opportunity to read and agree notes taken in the meeting and factual accuracy check of draft reports.

Type of Investigation

All incidents will vary in nature, severity and complexity and the level of response should be dependent on and proportionate to the circumstances of the specific incident. The levels of incident investigation are outlined below

This table provides an outline of the levels of systems-based investigations recognised in the NHS (currently referred to as RCA investigation). Within the NHS, most serious incidents are investigated internally using a comprehensive investigation approach. Resources to support systems-based investigation in the NHS are available online from: http://www.england.nhs.uk/ourwork/patientsafety/root-cause/

Level	Application	Product/ outcome	Owner	Timescale for completion
Level 1 **Concise internal investigation**	Suited to less complex incidents which can be managed by individuals or a small group at a local level	Concise/ compact-investigation report which includes the essentials of a credible investigation	(THGPCG Chief Operating Officer/relevant deputy), providing the principles for objectivity are upheld	Internal investigations, whether concise or comprehensive must be completed within 60 working days of the incident being reported to the relevant commissioner All internal investigation should be supported by a clear investigation management plan
Level 2 **Comprehensive internal investigation** (this includes those with an independent element or full independent investigations commissioned by the provider)	Suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist investigators where applicable	Comprehensive investigation report including all elements of a credible investigation	THGPCG Chief Operating Officer/relevant deputy. A decision may be made to commission an independent investigation or involve independent members as part of the investigation team to add a level of external scrutiny/objectivity	

Level 3 **Independent investigation**	Required where the integrity of the investigation is likely to be challenged or where it will be difficult for an organisation to conduct an objective investigation internally due to the size of organisation or the capacity/ capability of the available individuals and/or number of organisations involved (see Appendix 1 and 3 for further details)	Comprehensive investigation report including all elements of a credible investigation	The investigator and **all** members of the investigation team must be independent of the provider. To fulfil independency the investigation must be commissioned and undertaken entirely independently of the organisation whose actions and processes are being investigated.	6 months from the date the investigation is commissioned
National reporting templates should be used unless agreed that adaptions are required				

For incidents which do not reach the threshold for Serious Incidents, the investigation should be of a scale and scope which is proportionate to the incident to ensure that resources are effectively used and conducted to identify:

- The cause of the incident
- Whether the incident can be prevented from occurring again
- The actions taken to manage the incident
- Whether the actions were suitable and sufficient to manage the incident effectively
- Any post incident action, including further management, learning and changes to systems and practices which may prevent or mitigate a future occurrence.

The investigation should be based on a Root Cause Analysis process and may range from a simple fact finding to a full investigation.

Learning from Experience:

- Incidents in area of responsibility are investigated according to the severity of the incident, to identify what happened and why.
- Incident information is regularly reviewed and analysed to identify any patterns or trends that need to be investigated, this is done at Service Level by the Datix Approver. The Director of Quality & Assurance will review the organization Datix report monthly before noting any system issues and risks for the Quality, Safety & Governance Committee.
- Necessary actions and changes are implemented based on the findings of incident investigations and reviews
- Feedback from the review of an incident is discussed with those staff involved and the wider team as soon as possible.
- Learning for the organisation

Appendices

Appendix One

Serious Incident Review Panel
Terms of Reference

Introduction
The Serious Incident Review Panel of the THGPCG is a subcommittee of the Quality, Safety & Governance Committee. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the serious incident review panel.

Principal Function
The purpose of the panel is to ensure that THGPCG adheres adheres to the NHS England's Serious Incident and Never Events Framework and fulfils their responsibility to the management of serious incidents involving patients of the THGPCG services.

Membership
The membership will consist of:

(1) Medical Director
(2) Director of Quality & Assurance
(3) Governance Support Officer

In addition to the core membership the panel will co-opt additional members, such as Clinical Leads, secondary care colleagues or representatives from NHS England, as appropriate to undertake its role.

Chair
Chair arrangements will be agreed within the Serious Incident Review Panel. The Chair has the responsibility to ensure that the group obtains appropriate advice in the exercise of its functions

Administrative Support
Meeting arrangements, minutes and other administrative support will be provided by the Governance Support Officer. All meetings will produce an action log with notes of any decisions reached.

Quorum & Decision Making
A minimum of one Director level plus one other member of the panel is required for a quorum

Frequency of Meetings
The Panel will meet monthly when activity is required. The panel will be stood down if there are no serious incident cases to consider. Panel members are expected to attend every meeting

and to report, via a deputy or submit in writing, to the chair any information they are expected to contribute.

Agendas and papers
The agenda will be agreed with the Chair and circulated by the Governance Support Officer at least 5 working days in advance of the meeting.

Remit & Responsibilities

a) The panel if to comply with NHS England's Serious Incident Framework and Never Events Framework
b) To monitor levels of reporting and compliance with the agreed Serious Incident Policy
c) To ensure appropriate reporting in line with the THGPCG Policy for Incident Management and Reporting including Serious Incidents
d) To receive reports on serious incidents from services and review these for quality assurance on robust serious incident investigation and management
e) To monitor progress against identified actions, making recommendations for further actions as appropriate
f) To request further information in relation to serious incidents to ensure robust performance management arrangements are in place in services
g) To ensure that learning from serious incidents is identified and shares through the appropriate mechanisms, including quality review groups.

Reporting Arrangements
The panel reports to the Quality, Safety & Governance Committee through the provision of a serious incident update report monthly

Policy & Good Practice
The panel will apply best practice in it's decision making and will ensure that decisions are based on clear and transparent criteria. All panel members will comply with the THGPCG policy and procedures for the declaration of interests

Conduct of the Panel
All members of the panel, including co-opted members will comply with the NHS Code of Conduct for Managers and the Nolan Principles

Date of Review
The panel will review it's performance, membership and these terms of reference at least bi-annually. Recommendations for any changes to the terms will be made to the Quality, Safety & Governance Committee. No changes will be made unless they are agree by the committee.

Approval Date: 1/2/18
Review Date: February 2020

Appendix Two

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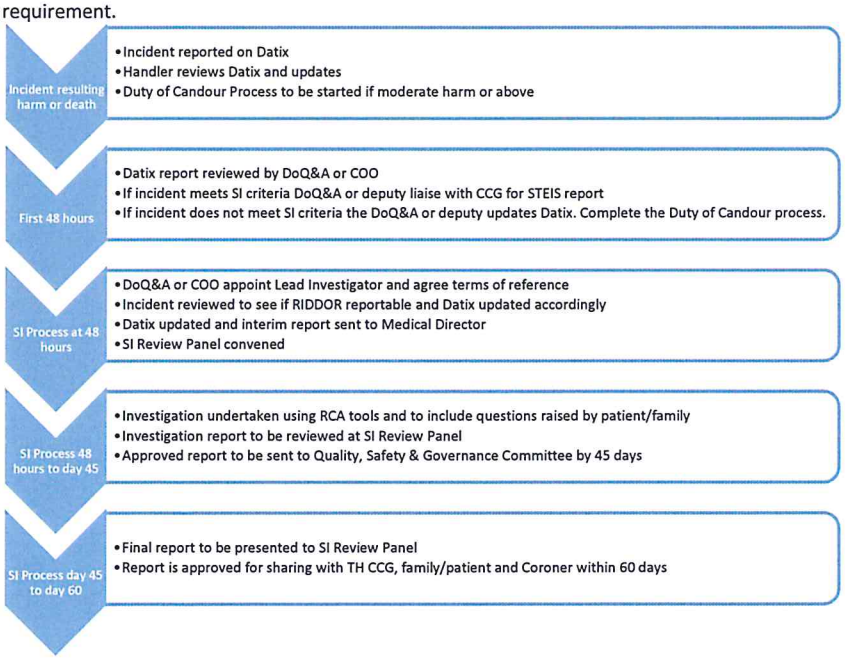
THGPCG SI Process Map

Please use this flow chart in conjunction with the Duty of Candour Policy whilst remembering that engagement with patients/carers or their families and loved ones is much more than a legal requirement.



Appendix Three

Concise Investigation Template

Concise
Investigation Report

Comprehensive Internal or Independent Investigation Report

Comprehensive &
Independant Investig

Appendix Four

Definitions

Abuse	A violation of an individual's human or civil rights by any other person or persons. Abuse may consist of single or repeated acts. It may be physical, verbal or psychological; it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm, or exploitation, of the person subjected to it. This is defined in *No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse* (DH 2000), and *Working Together to Safeguard Children: A guide to inter-agency working* states that abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by 'inflicting harm' or by failing to act to prevent harm (DCSF 2006, p37).
Accident	An unplanned and unwanted event that results in a loss of some kind. An accident does not include near misses.
Adverse event	An adverse event could be an incident complaint or claim that requires investigation by the service areas to identify causal factors. An adverse event may not initially have been recognised and reported as an incident (and so may need reporting retrospectively).
Adverse Incident	Also referred to as an ***incident or untoward incident***. An unintended and/or unexpected event or a circumstance that actually leads to, or could have led to, harm, loss or damage to a service user, staff member, visitor/contractor or property. Harm may be physical or psychological.
Being open	Service users, relatives, carers, staff and partner agencies need to know when something has gone wrong and what the Service Areas is going to do to minimise harm and prevent recurrence. Service users, carers, relatives and staff can expect to be provided with appropriate information and support following any patient safety incident by the Organisations. See the THGPCG's' Duty of Candour Policy for further guidance.
Causal Factors	A causal factor is something that led directly to an incident.
Just Culture	THGPCG aims to work within an open honest and just culture in which staff can be assured that they will be treated fairly and with openness

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	and honesty when they report adverse incidents or mistakes
Management Fact Finding	Following initial reporting this is a further information gathering and 'risk scan' that will help determine what happened, any obvious gaps or failures in the systems (where immediate risk reduction measures may be needed) and identify the requirements of further investigation.
Hazard	A danger – something with the potential to cause harm
Incident	An event or circumstance which could have resulted, or did result, in unnecessary damage, loss or harm to patients, staff, visitors or members of the public. The harm may be physical or psychological. It is important to recognise and report ***all*** incidents, both clinical and non-clinical. The Service Areas uses the word **incident** because this is the term that staff recognise and use most frequently - although ***untoward Incident*** or ***adverse event*** may be technically more accurate
Investigation	A thorough, detailed, systematic inquiry, search or examination to discover facts. Usually results in recommendations, actions and sharing lessons learned as a result of the incident.
Likelihood	The possibility or probability that an incident will occur or reoccur
NPSA	The now dissolved National Patient Safety Agency (NPSA) – was a NHS body which supported the NHS to learn from patient safety incidents and develop solutions to prevent harm in the future. The NPSA: • Collectedand analyses patient safety incident data via the NRLS
NRLS	National Reporting and Learning System (NRLS) - a data base operated by the NPSA. All NHS organisations provide information about individual patient safety incidents, to enable the NPSA to analyse national incident data and support the NHS to improve patient safety.
Near-miss or **Close-Call**	An incident where an event or an omission does not develop further to cause actual harm - but did have the realistic potential to do so. These should be reported as incidents. **Near-misses** are ***free lessons*** and are as important in terms of the way we learn lessons as those events where actual harm, loss or damage has occurred. A '**near miss' incident** could be any severity grade.
Never event	Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. These are updated on an annual basis and are available on the Department of health website https://improvement.nhs.uk/resources/never-events-policy-and-framework/

Patient safety	The process by which an organisation makes patient care safer. This involves identifying, analysing and managing patient-related risks to improve and make services safer. Reporting, analysing and learning from incidents is an important part of this process.
Patient safety Incident	An incident related to patient care or treatment, which could have or did lead to harm for one or more patients receiving care from the Organisations. *National Patient Safety Agency (NPSA) definition.* Sometimes called an adverse healthcare event, a clinical error or incident.
CCG	Clinical Commissioning Group
Permanent harm	Harm directly related to the incident and not to the natural course of the patient's illness or underlying conditions; defined as permanent lessening of bodily functions, including sensory, motor, physiological or intellectual
Prolonged pain and/or prolonged psychological harm	Pain or harm that a patient has experienced, or is likely to experience, for a continuous period of 28 days.
Risk	How likely it is that the harm from one or more hazards/dangers will happen and the consequences or impact that it would have. The chance of something happening and the impact it would have.
Risk Assessment **Risk management and reduction**	A systematic way of: 1. Identifying hazards and risks 2. Deciding what harm could result, to who or what and how 3. Reviewing if these hazards/risks are adequately managed. 4. Taking action to control or limit the hazards or risks 5. Reviewing the effectiveness of the assessment and action plan 6. Recording this process
Risk Grading and the Risk Grading Matrix	Grading the severity of an incident to enable us to make informed decisions about subsequent actions and to analyse incident patterns and trends. The Organisations uses a Risk Grading Matrix to grade incident severity The grade of severity is based on the **likelihood** of something happening and the **impact** it would have if it did happen.
Risk Management	Systematically applying policies, procedures and practice (in the context of the Organisations' purpose and objectives) to: 1. Risk assess - based on identifying and evaluating hazards 2. Implement measures to control or manage the risk 3. Regularly monitor and review the risk This process can be recorded and monitored using a risk register (see Organisations' Risk Management Strategy)

Risk Reduction	Reducing the level of risk of recurrence by implementing identified actions e.g. as a result of lessons learned from an incident.
Risk Register	A risk management tool used by organisations to record, prioritise and monitor identified risks. See Risk Management Strategy.
Root Cause Analysis (RCA)	A systematic retrospective review of an incident undertaken to identify what, how, and why it happened. The analysis is then used to identify areas for change, recommendations and sustainable solutions, to help minimise the re-occurrence of the incident type in the future.
Safety Culture	A commitment to make the organisation as safe as possible for service users and staff by following policies related to risk and safety and openly reporting incidents and safety concerns.
Security incident	From April 2010 NHS Protect introduced a *Security Incident Reporting System.* This was developed to provide a clearer picture of security incidents across the health service in England, locally and nationally. This is a key step towards building a safer NHS where people and property are better protected. SIRS coincides with the extended requirements for reporting to NHS Protect. The following security incidents must be reported using SIRS: • any security incident involving physical assault of NHS staff; • non-physical assault of NHS staff (including verbal abuse, attempted assaults and harassment); • theft of or criminal damage (including burglary, arson, and vandalism) to NHS property or equipment (including equipment issued to staff); and • theft of or criminal damage to staff or patient personal property arising from these types of security incident.
Serious Incident **(SI)**	A serious incident requiring investigation is defined as an incident that occurred in relation to NHS funded services and care resulting in one of the following: • the unexpected or avoidable death of one or more patients, staff, visitors or members of the publicpermanent harm to one or more patients, staff, visitors or members of the public, or where the outcome requires lifesaving intervention or major surgical/medical intervention, or will shorten life expectancy (this includes incidents graded under the NPSA

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	definition of severe harm (refer to appendix 2) a scenario that prevents, or threatens to prevent, a provider organisation's ability to continue to deliver health care services, for example, actual or potential loss or damage to property, reputation or the environment; allegations of abuse; security incidents; adverse media coverage or public concern for the organisation or the wider NHS; or one of the core set of *Never Events*.
Severe harm	Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS funded care.
Unexpected death	Where natural causes are not suspected; local organisations should investigate these to determine if the incident contributed to the unexpected death.

Appendix Five

The levels of harm used for patient safety incidents as defined by the National Patient Safety Agency

No harm	Impact prevented – any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people Impact not prevented – any patient safety incident that ran to completion but no harm occurred to people receiving care
Low	Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving care
Moderate	Any patient safety incident that resulted in a moderate increase in treatment (e.g increase in length of hospital stay by 4-15 days)and which caused significant but not permanent harm, to one or more persons receiving care
Severe	Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving care. □ Chronic pain is continuous, long term pain of more than 12 weeks or pain that remains after the time that healing would have thought to have occurred, after trauma or surgery □ Psychological harm is an 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)
Death	Any patient safety incident that directly resulted in the death of one or more persons receiving care.

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Non-Patient related incidents (e.g staff related incidents) This is also

used for Risk Assessments	
Negligible	□ Minimal injury requiring no/minimal intervention or treatment. □ No time off work
Minor	□ Minor injury or illness, requiring minor intervention □ Requiring time off work for >3 days □ Increase in length of hospital stay by 1-3 days
Moderate	□ Moderate injury requiring professional intervention □ Requiring time off work for 4-14 days □ Increase in length of hospital stay by 4-15 days □ RIDDOR/agency reportable incident □ An event which impacts on a small number of patients
Major	□ Major injury leading to long-term incapacity/disability □ Requiring time off work for >14 days □ Increase in length of hospital stay by >15 days □ Mismanagement of patient care with long-term effects
Catastrophic	□ Incident leading to death □ Multiple permanent injuries or irreversible health effects □ An event which impacts on a large number of patients